EXHIBIT M

AFRAAZ R. IRANI,
vs.
PALMETTO HEALTH-RICHLAND

COMMITTEE MEETING IN RE

TERMINATION OF DR. IRANI

Due to the quality of the recorded media, portions were unable to be transcribed. The transcript may also include misinterpreted words. The transcriber was not present at the time of the recording; therefore, this transcript should not be considered verbatim.

AUDIO RECORDING WAS TRANSCRIBED BY:
Sherri L. Jolley
Midwest Litigation Services
711 North Eleventh Street
St. Louis, Missouri 63101
(314) 644-2191

T R A N S C R I P T I O N

MS. HILL: (unintelligible) your time. I've already briefed the committee this afternoon on their responsibilities, so I'm going to go ahead and get started. As I introduce people, if you will -- I don't -- have it written down, but probably not in order. So if you'll just raise your hand as I introduce you.

I am Gwen Hill. I'm the interim vice president here at Palmetto Health, in human resources. My role today is the moderator of this committee. I will not be a decision maker or a voting member of this committee.

All right. We're here to consider the matter of Dr. Irani's termination (unintelligible) Dr. Irani is sitting here on the left.

I will introduce everyone. Assisting Dr. Irani is Lynn Hearn (ph), human resource business partner. Representing management today is Dr. Walsh and Dr. Koon. The HR business partner assisting management is Donna Brown. Today's committee members are Mohan Sridaran, resident general psychiatry; Zach Brock, resident, surgery; Allie Giddings, faculty OB/GYN; Davinder Lally, faculty, internal medicine; and Eric Brown, faculty, emergency medicine.

Dr. Irani, the grievance committee members understand the seriousness and the confidential nature of these proceedings. All in the room have been asked to sign a form

indicating they acknowledge the information we hear today is considered as confidential as any information used by Palmetto Health, just as you've been asked, along with your (unintelligible) sign that.

My role, again, is the moderator. I'll keep us on task and on time. You're free to share information relevant to today's proceedings. However, if you circle back and repeat, I may ask you to move forward.

We will first hear from management. They will have up to one hour to state their case. After they finish I'll ask the committee if they have questions. After the committee has finished its questions, I will ask you, Dr. Irani, if you have questions. Please direct your questions to me during this time.

After you finish with questions, you will have up to an hour to state your case. Likewise, after you finish, the committee will have an opportunity for questions, and management will then have an opportunity for questions. Make sure you direct your questions to me, as well.

Then management will have five minutes to give a concluding statement, followed by your five-minute concluding statement. After the concluding statement, I'll ask the committee if they're ready to vote. If they are not ready, they will ask additional questions. At that point, both management and the employee will be excused. We will let both sides know

the results of the vote by the end of today.

Does anyone have any questions about the process we'll follow?

None? All right. We'll get started then.

DR. WALSH: I want to introduce myself for those of you who don't know me. I'm John Walsh. I'm the chair of orthopedics. David Koon is our program director. Everybody who you are going to hear about as faculty members for orthopedics was present during the entirety of Dr. Irani's residency, with the exception of Dr. Grabowski, who started last August.

And the way that we're going to do this is Dave is going to present the details of the case, and then I'll kind of flesh things out and -- as they -- as they develop. These are copies of e-mails and supporting documentation for Afraaz's termination.

DR. KOON: I'm Dave Koon. I've been program director for the department of orthopedics since 2006. I came on staff in 2002. I'm a graduate of the University of South Carolina School of Medicine. I finished in 1992. I served ten years in the United States Army, got out in 2002, came to work here at the University.

What I'd like to do today is start and kind of describe the events that have occurred over the past couple of years. And the bottom right-hand side of your pages are numbered, and I'll refer to those numbers as we go through the

discussion.

Dr. Irani was a very impressive orthopedic applicant to our program several years ago. He was born in California, and he actually double majored at Stanford and attended Stanford School of Medicine. He had multiple awards and publications and research documentation. He had an excellent dean's letter.

He scored a respectable 223 on Step 1, and had a very impressive interview with us two years ago. We were really happy to have Dr. Irani join us. And I believe he was in the top 12 of our applicant ranking, so he was highly sought after when he came here.

He started his internship in 2010, in July. He had the same rotation schedule as our other interns. In orthopedics they're allowed to have three orthopedic rotations, and the first few months were off-service. So we had fairly limited exposure to Dr. Irani to start off with.

I began hearing some concerns from the other services, some general attending comments in the hallway, and specifically came to light when the trauma case managers came to me one day and said, you know, "Dr. Koon, we usually don't have problems with your residents, but here are some issues we're having," and they were issues with time management and not attend -- completing assigned tasks and things like that. And I said, "Fine. I'll take care of it."

Please note that this is highly unusual for

orthopedic interns. Usually our interns do very well. You know, we have attendings say, you know, "I want your intern in my program, and we're going to try to recruit them away from you," and things like that. And so having complaints against one of our interns was unusual. And so I asked the chief residents to handle it, which is what I usually do; you know, "You guys talk to Afraaz, see what the deal is and, you know, take care of it." And that was the last I heard of that.

The concerns continued, and in December of 2002, while we were walking down the third floor hallway and downstairs, I ran into Afraaz as I was walking across the street to the office, and I talked to him a little bit about it, got his side of the story, and told him that, you know, it was kind of a rough way to start your internship, but he was getting ready to go on an orthopedic service.

I said, you know, "You've got a brand-new chance to shine, new attendings, orthopedic attendings. You know, here's your chance to not necessarily start over but open -- or turn the page and get a better start on things."

His -- if you look at our New Innovations evaluations -- those are at Pages 1 through 17 -- there are several things that I would like you to take a look at. On Page -- first of all, if you look at the first several pages you'll see that on a scale of one to five, Afraaz was starting to get some twos on some of his evaluations. Now, we recognize that

there are different attendings who have different ways of evaluating people, but, again, it was unusual for us to start receiving this type of evaluation from our interns.

If you turn to Page 5, you'll notice additional comments. On the top was a comment by Dr. Jones, "I was not confident that Dr. Irani was completely invested in caring for our patients. He did not give me the feeling that he was always truly aware of what was going on with our -- with the patients he was managing on the trauma floor." And that was similar to one of the other attending comments that I had in the hallway.

Dr. Bynoe writes down in the -- Line 12, "Could've been more interactive on the service." I noted in 12 -- Line 12 that his handwritten notes were essentially illegible, which is something that he and several other residents have, and so I was just going to give him a hard time and -- we actually had one resident that we made stop -- start typing notes because no one could read his notes, and it was, you know, not very helpful for other people on the service, so -- but anyway, that was the comment that I had written.

Dr. Jones again says, "He has not shown that he has the desire he requires to support -- my support for caring for my family." Those are very, very unusual comments for us to receive about an intern on our service.

They continue onto Page 6, "He needs to step up to being a doctor and become accountable and invested in treating

patients." And then Dr. Jones says, "Overall, still needs to take responsibility for total patient care if they are his patients."

And then I note in the middle of the page at Line 23, "I've spoken to Dr. Irani at length about his performance thus far in his internship, and he needs significant improvement in several areas. And he seems to understand these issues." So this is something that I had spoken with Dr. Irani on several occasions, and I've made a note of that.

If you turn to Page 12, another evaluator, Dr. Mostriani (ph) notes, "Needs to take greater responsibility for the welfare of the patient. Too often would fail to recognize the need for urgency in patient care."

If you turn the page to 13, Dr. Ross, who was his chief resident at the VA, says, "Dr. Irani had a rough start at the VA where I first had occasion to work with him. He seems to lack motivation and lack consistency in his patient evaluations and care plans. However, I did see marked improvement by the conclusion of the rotation.

His unique personality seems to get in the way of interpersonal relationships, both with peers and staff. He is highly intelligent and his core medical knowledge is excellent, but he needs to temper this with a greater desire to improve his core surgical knowledge base and skill set. I think that he has the incredible potential to become an excellent surgeon, but he

needs to develop motivation and people skills to succeed."

So, again, I note that these were highly unusual for our orthopedic interns, and he actually was -- Dr. Irani was met by all three chief residents in 2010 to discuss these issues and seek improvement, which was highly unusual. It's not unusual for the chief residents to be asked to take care of problems with the junior residents, but it was very unusual for us to ask all three residents to do that for Afraaz.

He did transition to PGY 2 year in July of 2011, but the concerns persisted. And if you note on Page 17, these are several of the comments that he had during his PGY 2 year. And the only reason I'm kind of jumping ahead a little bit, because I'm not going to -- I'm not going to go back to the New Innovations evaluations again, so I just thought it would be worthwhile to look at some of these comments.

Dr. Voss notes that, "Somewhat slow and seemed to not be driven by concern for the patient. Punctuality on rounds was a concern. The trauma service is very busy, and he was late for rounds several times. His patient care was inconsistent." And so we have another evaluator who's noting some of the same things that he had problems with as an intern.

Dr. Mazoue, one of our sports attendings, notes that, "He also needs to work on his social skills with his professional colleagues -- for example, OR personnel. In

addition, he needs to work on time management and efficiencies, especially in the OR." And then Dr. Voss, on the second-to-the-last notation, "Needs to improve empathy for the patient." So all these concerns that we had near the initial year and a half of Dr. Irani's training.

In July of 2011, Dr. Irani was involved in the care of Mr. B, who was a trauma patient.

DR. WALSH: Brand-new PGY 2.

DR. KOON: Right, he's a brand-new PGY 2 resident. And his initial -- Dr. Irani's initial eval with his patient was 11 July, so 11 days into his PGY 2 year. I heard of this through a friend of mine who is a nurse in the emergency room. Diane Savage is her name, and you'll see her name listed on several of the e-mails. Diane has over 26 years of emergency department nursing experience. Diane had an encounter with Dr. Irani and Dr. Iaquinto, and that day documented her experience and what happened in the ED.

Dr. Irani evaluated Mr. B at the request of the trauma service. In his notations, he did a very brief history and physical examination where he noted that the sensation was intact to light touch; and then when evaluating his nerves, that he had a radial pulse. He noted that the patient had an open both-bone forearm fracture, that his hand was rotated 180 degrees, and that he was moving his fingers.

I would consider this fairly inadequate

documentation for a patient in the trauma room. There's no mention of wound debridement, vital signs, pain medications, wound measurements, grade of open fracture, antibiotics given, tetanus, splinting, and there were inadequate radiographs obtained by the orthopedic resident that day, because there was only one single view. There are no post-reduction images, and there was only wound management basically by the ER.

The only other documentation we have from Dr. Irani regarding Mr. B was a very brief preoperative note that he wrote the day before he was to go to surgery.

In short, the patient had an injury with, I believe, a metal lathe, and Dr. Walsh was actually involved in his care at a later time. That night, Diane Savage documented her experience, and that was on Page 20. And I'll ask your forgiveness. The ER threads are in chronological order, backwards. And so the first -- the first note will be on the 20th, and then we're going to go back to 19 and 18.

So Dr. -- Diane had concerns about Dr. Irani's wound manipulation, compassion that he did not show to the family. Diane says that she asked him to stop manipulating the extremity so she could get pain medicines, and Dr. Irani basically refused. And this was noted by Dr. Spencer Robinson as well.

There was some discussion about how much irrigation was used in the initial wound management by the ER physician, and Dr. Irani says -- stated that -- Diane says Dr. Irani

stated that, "You used two, right?" She said, "No. We used one." And then there was a little bit of back and forth where Diane was under the impression that Dr. Irani wanted her to state that there was two liters instead of one being used. And then Dr. Iaquinto comes down and manipulates the extremity as well.

This -- her view of the events was sent to Alice internally, the director of nursing; Dr. Cadalano (ph); and then to Dr. Stevens. Dr. Stevens forwarded the note to me at 10 August, and I immediately forwarded that to Dr. Irani, which is on Page 19, for his explanation. Dr. Irani sent me his explanation that night, and that is on Page 18.

Also, his recollection of events was forwarded to Diane for her review, just to say, "Is this consistent with what happened?" Please note that Dr. Irani's version of the events was almost one month after the fact.

Several questions come to mind when I was reading Dr. Irani's evaluation. First, he notes that he made a note about the pain medications, but it's unclear whether he asked Diane about the pain medications or not. Her recollection was that he did not ask about the pain medications.

So his -- he wanted to inspect the wound, see his pain level before approving a possible overdose of narcotics in an 80-year-old male. But Diane notes that he never asked about the pain medications. I'm not sure exactly what Dr. Irani means

by "see his pain level when inspecting the wound." And it's unsure whether he removed the splint or not.

Dr. Irani also says that -- on Page 19, second paragraph, he says, "The patient was very thankful throughout, and when I saw him on the floor we've had great interactions." But there's only one documented visit, and that was two days later, which included a brief op note. So I'm not sure how many interactions he had, were any documented, and there's no documentation of a postoperative check that day.

Again, Diane notes that there were three witnesses that documented the encounter that she recollected that night of surgery. Dr. Irani also says that, "It was a regrettable decision but one that had to be done. Many of the staff were justifiably horrified at this and wanted us to do more."

I'm not sure who he's speaking of, "wanted us to do more," and who was justifiably horrified. Diane Savage notes in her review that the wound was impressive but not the worst she's ever seen.

Dr. Irani later accused Diane of lying about the irrigation amount. And when I asked him why she would make this up, he really had no answer. For her to have an encounter, document it that night, and make something like that up would be highly unusual in my knowledge of her.

He also states that it's -- he stated that it was the right thing to do. And when I reviewed his physical exam,

I'm not sure that there's -- there were indications for a primary amputation in this patient. Again, Dr. Irani noted that the nerves were intact, he had a good radial pulse, and could move his fingers, so I wasn't sure that it was indeed the right thing to do.

His version of the events that day seems to be directed at her version rather than documenting the patient care. And so we had concerns that day, and given those concerns led us as a faculty to develop the memoranda for record which is dated 15 August, which is Page 22.

And I'll just briefly review this. "Dr. Irani demonstrated a significant lack of compassion and empathy in the patient's care on the initial trauma resuscitation. Mr. B sustained a near forearm amputation. Dr. Irani failed to provide adequate pain medications and ignored nursing requests for same during his initial evaluation. In this encounter, he requested the nurse to lie about his initial irrigation/debridement of the wound."

Number 2, "He had repeatedly demonstrated poor communication skills with patient's family, peers, and attending." And this was a concern that the faculty had not only with his initial internship but also with us during the first month that he was on our service.

"He has repeatedly demonstrated poor time management with frequent tardiness to required conferences, clinics, and

the operating room." And that's noted on several of the comments that we've already looked at on the New Innovations.

"He does not demonstrate effective prioritization of clinical duties, which has resulted in other duties for residents." That was something that two of the junior residents stated that they had extra work to do because he wasn't either efficient in the emergency room or efficient on call with his on-call duties, so I felt that was something that needed to be included in his remediation.

Number 5, "He has provided substandard care." One of the substandard cares was he closed a wound while Dr. Abel (ph) was on call with a Vicryl suture, and that's something that he never saw one us do, and I don't know if he ever read it in a book, but that was something Dr. Abel, who is one of our locum tenums doctors called me and said, "Are you -- you know, basically, what's the deal?" And I said, "I don't know what you're talking about." He said, "Well, one of your residents closed a wound with Vicryl." And so when --

DR. WALSH: Externally.

DR. KOON: Externally. And that was just something that, you know, we would not consider appropriate.

He also was involved in a patient of mine when I was on call one night. He got a call from the emergency room at the VA about a patient who was in the early postoperative period after a total knee arthroplasty. The patient had developed

cellulitis on his leg. And after a telephone discussion with this physician, Dr. Irani made the decision that he didn't need to see the patient; that Medicine needed to see them, to admit the patient, even though the patient was I believe around ten days after a total joint.

Number 6, "He received substandard evaluations during his internship," which we've already gone through.

And Number 7, "He displayed a significant lack of attention to detail in his initial PGY 2 rotation," which was actually with Dr. Walsh.

Given the fact that we had verbal counseling with residents, verbal counseling with faculty, and the degree of the things that we were seeing this early in his internship, we as a faculty discussed it and recommended to the executive committee of the GMEC that these -- this remediation plan be implemented.

After their approval, we recommended three and a half months of remediation of this document. This was discussed with Dr. Irani and Paul Lathey (ph), who is our business manager at the office, on the 15th of August, which is Page 23.

So the middle of the page is just my notes to Dr. Walsh stating that I discussed it with him, that it had been approved by Dr. Raymond and Dr. Stevens, and that it would be implemented pending full vote in the GMEC at the next meeting.

Initially, when Dr. Irani was presented with the

facts in the memorandum, he did not agree with some of the points and complained that some were too vague. He initially laughed about some of them and appeared not to take them very seriously. He then proceeded to offer excuses or rationalize each point that was noted in his deficiencies and argued that he was misunderstood.

The only item that he -- in which he agreed to was Item Number 5, that he had not -- should not have closed the wound with Vicryl. And that's when he accused Diane of lying about the events surrounding Mr. B's care.

So I informed him that these were the recommendations of the department, that it was -- that the executive committee would probably approve it pending full vote. I encouraged him to review the policy on academic remediation. He was allowed to respond to each item in the memorandum and ask questions.

And I informed him at that time that failure to meet the remediation measures could result in remediation or continued probation or possible termination from the program. I gave him a copy of the memo and informed him that he could respond in writing to our recommendations.

23 -- at Page 23 is that -- this was discussed with Irani and approved.

Page 24 is the approval by the GMEC executive committee on the 15th of August.

Pages 26 through 28 are Irani's response in an e-mail -- a response to the remediation measures in an e-mail to Kathy on -- Dr. Stevens -- I'm sorry -- on the 22nd of August.

Several things that surprised me about Dr. Irani's response is that if you see in the fourth paragraph from the bottom it says, "I always demonstrate the highest level of compassion and empathy in patient's care." And these basically were not based on other attendings' evaluations.

Throughout his response, he says that he was misinterpreted and that others just -- there was a perception that was in error. He says in the second paragraph from the top -- from the bottom, "Regarding the accusation about my lying about patient care, this is a misinterpretation." And that's one thing that we see again and again, that it's somebody else's perception or it's a misinterpretation of what he said or what he meant.

He states that he did everything right regarding Mr. B's care and that he had already been given pain medicine even though he didn't ask. And, initially, during my evaluation with him on this topic, he accused Diane of having frequent encounters which were not the best in the emergency room with the orthopedic attendings, and that was one way he tried to explain away that.

Regarding Number 2, that he demonstrates poor communication, and the top of Page 27, that he says that he

appreciates the fact -- and, again, in the second line, he may have been misunderstood, and so he's going to make efforts to improve communication.

Regarding 3, he doesn't really say anything about an excuse of why he's continually late for conferences and the operating room and frequent tardiness to clinics.

In Item 4, he says that he's again misunderstood and that there's perceived tardiness by the attendings. He says, "I always complete my work and I often stay beyond the recommended work hours so as not to burden other residents." All of our residents know that the duty hours is non-negotiable and that you have to abide by them, so never has any faculty or other resident asked him to stay beyond the recommended duty hours.

Number 5, he did provide substandard care, and actually admits to that, "Whenever I've been notified of my errors, I proactively make improvements."

Number 6, he does not disagree with the substandard evaluations that he has. He actually agrees with them and made significant improvements based on the suggestions that were provided to me.

And Number 7, he's a little bit -- he misunderstood what we meant about the attention to detail. That attention to detail was regarding Dr. Walsh and the history and physical examinations in the clinic.

I don't know if you wanted to say anything about

that or not.

DR. WALSH: Just briefly. When I see a patient in the office who's going to need surgery, either I or the resident will fill out a history and physical at that point. And Afraaz had rotated with me for -- well, for a number of weeks at that point, and I had noted -- generally speaking, at the end of the day, the residents go on up (unintelligible) my dictations and I go through and proof everything, and I noticed that there was repeated mistakes on the H&Ps, so I brought it to his attention. It was a day that we had had several patients who needed surgery.

I sat down, was correcting the first one. Afraaz was still there at that point. Countless mistakes were brought to his attention. He corrected them. I turned to the second one, exact same thing -- more mistakes. And so I said, you know, "Why don't you, right now -- while I'm still dictating, why don't you go through these things, fix the things that you can see are in error, and take care of it." So he did that.

For the most part, he was able to identify things that he had either omitted or incorrectly documented. The real issue was subsequent to that when he was doing H&Ps beyond that. He either would omit the same things he was before, he would omit other things, he would make the same mistakes, including grossly inadequate documentation -- an extremity exam or -- kind of what the whole point of the H&P is in orthopedics.

And I asked him, I said, you know, "Afraaz, this -- you know, if you've had the things identified to you and you fix them, and now you continue to make mistakes, but they're always different. It's like every H&P there's something you're leaving or forgetting or, sorry I didn't take care of that or whatever. It just seems completely casual, like you don't care. And there isn't something that's a -- something I can identify, oh, you're not understanding this; let's fix it and take care of it. It just is this scattershot kind of thing that is constantly changing, and basically the -- what it communicates is I don't really care."

DR. KOON: If you look on Page 29, this was an e-mail from me to several people just to give an outline of what we were going to do during his remediation process. So I wanted to have complete transparency. I wanted it to be on a schedule. And I wanted other people involved so it would not appear to be a program director versus resident issue. I wanted multiple people involved, and this included chief residents as well. Paul Lathey was included because he's our business administrator who has HR experience.

Dr. Irani was included in the process, and we actually had to change one of his meetings because he was post-call. So this was not something that was set in stone. If something needed to be changed, we'd be more than happy to change it.

Page 30 is Dr. Stevens' e-mail noting her decision.

She illustrates knowledge of the appeals process. She alludes to the GME policy on appeals process. And Dr. Irani subsequently decided not to request a grievance hearing on this remediation measures -- these remediation measures. So there's no accusation of lack of or unfair due process or appeals policies.

Page 31 is an e-mail -- Page 31 and 32 is a memorandum from Dr. Walsh regarding a meeting that he and Dr. Grabowski had with Afraaz.

DR. WALSH: Well, it's a relatively detailed memo, and I think the thing at this point -- you know, he began in July of 2011 where he's full-time in orthopedics. This is three months later. And what I'm attempting to summarize in this memo has to do with his performance as an intern on other services, his performance as an intern when he was rotating in orthopedics, and the time period there between July 1st, 2011 and the latter part of September.

And it's the same thing that I described a moment ago about his performance in H&Ps. It's a checkered behavior that is related to -- it's related to his behavior, it's related to follow-through, it's related to his willingness to accept responsibility, to perhaps initially accept responsibility verbally, and it made zero difference whatsoever in terms of his future behavior after that. So there's some specifics that I tried to address relative to surgical skill and so forth. Most

of these things are -- Dave has already covered.

If you look at the bottom of the first page, I'm aware of that particular patient with the complex forearm injury because of my role in his care and subsequent care there. And when I talked to Afraaz about that, one of the things that he repeatedly mentioned was that, "Well, I knew him after this was all over with, and he was an inpatient and we had a great relationship and things were okay."

And I explained to him that's a patient who has had major trauma, has had different forms of sedative medications; then they had general anesthesia. More often than not they're amnestic for everything prior to that point.

So the fact that the patient had a good relationship with him later didn't in any way support the fact that he had done the right thing prior to that, and that the real direct observation or information that we had about his care for that patient beforehand was related to the patient -- or to the hospital staff members who were present and not to patient's recollection several days later.

DR. KOON: Page 33 is a memorandum of record that I wrote just basically stating that we again met with Afraaz. We reviewed his six-month evaluation. We solicited his opinion and feedback and progress, and we reviewed each remediation measure and provided feedback. And that was Dr. Walsh and I met with him.

And I know that he appeared to gain some insight into his deficiencies. He was on Dr. Guy's service and was enjoying that. And Dr. Guy had been working with him on communicating effectively. And Dr. Guy is definitely our best communicator.

And that he -- he does note that -- I did note that he had appealed through the grievance process as outlined in the resident manual and that his appeal was subsequently denied by Dr. Stevens. And then I said we'll meet with him again.

Pages 34 and 35 are the second memorandum that I wrote after Dr. Jennifer Wood, who is a chief resident, and I met with Afraaz in the prison clinic. Dr. Irani continued to have problems completing assigned tasks. He was just having problems on the ward.

And Dr. Wood had actually asked him to do things that he had not done, and one of those was as simple as the morning list -- print off the morning list each day, get some vital signs, get current labs. And after repeated instances of Dr. Wood telling Irani to do it, it basically wasn't done so she started having the medical students do it instead. And that was something that she addressed with him that morning.

Page 35 is -- the bottom one is an e-mail that he sent to me one Thursday night about a patient that he had dictated a transfer summary, and sent me a message stating that he had never participated in the patient's care; Dr. Hoover did

the H&P; and the patient transferred from the VA, and the only thing I can think of is Dr. Wood asked me to put in the discharge order. And so he did the discharge summary afterwards.

And I sent him a very terse response back stating that, as a junior resident of a health team, his sense of entitlement was somewhat astounding, that he would write an attending, in the midst of academic remediation, that note, after I'd asked him to do that same thing three separate times. And so part of that was included in that memorandum as well.

He had been verbally counseled regarding inappropriate patient care during a pain management problem with one of Dr. Walsh's postoperative patients during this time, where he had instructed the patient to take an inordinate dose of narcotics in the postoperative period.

When we discussed this with him, he asked me about the -- what my thoughts were about his remediation, and I said, "Well, I think you'll probably go from Level 2 to Level 1," and this seemed to irritate Dr. Irani. He kind of sat back and rolled his eyes and let a big sigh and said, "All that's going to do is increase my overhead."

And I had no idea what he was talking about, so I said, "Afraaz, what are you talking about?" And he went on to describe his keeping of a log, documenting when he answered pages and when he got to clinic and when he got to the OR so as

to disprove any allegations of tardiness.

During that same time frame, on the 25th and 27th, I had a postoperative patient who had manipulation and had wound drainage after that manipulation. The patient called Dr. Irani twice over the weekend, and not once did Dr. Irani tell the patient to come in, be seen, and be evaluated. And this was less than four months after his -- a similar problem at the VA with another one of the postoperative patients.

On the 28th of November, Dr. Irani failed to abide by the attending surgeon's directions in a staff clinic, and became argumentative when confronted by the chief resident. Basically, this was an instance of a gentleman with a foot problem in the staff clinic. Dr. Grabowski said the patient needs a stat MRI. Dr. Irani discussed this with the head nurse and decided to let the patient go home and obtain the MRI on an elective basis.

When confronted with this by the chief resident he became argumentative and very defensive. And this was brought up in a subsequent faculty meeting, and even when confronted with Dr. Grabowski and Dr. Wood sitting in the room saying, "This is how it went," he refused to acknowledge a mistake or take responsibility for his actions.

And so, all of this together, I thought that we needed to meet with him as a faculty on the 5th and discuss all of these instances.

Page 36 is documentation -- or the memo of our meeting with him. We met with Dr. Irani for over an hour and included the vast majority of the orthopedic faculty. It included chief residents Hoover and Wood and Paul Lathey. We asked him several difficult questions, including, you know, "Do you really want to be in an orthopedic program? If you do, do you really want to be here?" Because we were getting the feeling that he just didn't want to be here and he wasn't happy.

Then the issue came up of him recording phone calls. Several of the residents had come to me with concerns that there were weird sounds when they were talking to Irani, and it was almost as if he was calling, knowing the plan but wanting it confirmed by someone more senior to him. And so I basically asked him if he was recording phone calls, and he admitted to secretly recording Dr. Abel, one of our trauma -- orthopedic trauma locums. And I asked him not to tape-record that faculty meeting.

We again reviewed his remediation measures, and he could not admit agreement to any of the initial remediation measures. He continued to complain -- to provide evidence of ongoing patient care and continued to display lack of effective teamwork within the residency framework.

After this faculty meeting, the department voted unanimously to place Dr. Irani back on Level 3 -- well, to place

him onto Level 3 remediation. There was a long discussion regarding timeframe for that. There were initial -- there were discussions for three months and six months and four weeks, and basically what we came to was we wanted to place him on Level 3 but not affect his graduation date.

So we were looking to the future. We were looking to fellowships and things like that. So instead of doing a three-month, we had agreed to a four-week suspension to allow him to have a time-out, to go home to California for a little while and to, you know, start fresh when he came back.

The -- that was on the 5th. On the 7th he was involved with a patient, trauma female 375. Trauma female 375 was a patient who had multiple orthopedic injuries, multiple severe injuries, and was cared for by different nurses than what were involved with the initial care of the trauma patient, Mr. B. That was on the 7th.

I heard about it on the 8th in staff clinic. And that afternoon I went to the ER to speak with Arlene Vance, Elaine Simon, and Diane Savage. I got the same story of the patient encounter from all three nurses -- very detailed accounts that were in agreement in all areas.

DR. WALSH: And speaking with them separately.

DR. KOON: And speaking with them separately. Yes.

One of the nurses said, you know, "Dr. Koon, I like

Afraaz. He's kind of a goofy guy. He's kind of Irani." "But," she said, "he's dangerous with patients." And then she went on to describe what happened.

The accounts vary. Pages 38 through 40 are Dr. Nathy's (ph) version of the accounts. Pages 41 through 44 are the nurses' accounts of the encounter. And Page 45 and 46 is Dr. Irani's encounter.

My understanding of what happened -- and the accounts varied from Dr. Irani's, "We did everything perfectly. The patient was well taken care of. Everything was as it should be," to the nurses, where not enough pain medications, inconsiderate with the patient being awake and talking about the patient in front of her, about her injuries, inadequate pain medication, not getting out of the way so blood could be hung in a hemodynamically unstable patient.

It was very, very disturbing what I heard that night from the three nurses. But they were -- okay. They were all in agreement, and therefore that is included on his trauma -- on the encounter, and our decision to speed up the remediation process. The faculty was acutely aware of -- acutely concerned for our patient's safety and had no choice but to recommend suspension while we further investigated the trauma female incident.

Let me reiterate, the trauma female incident was not a significant determining factor in his Level 3 remediation. It

was just the one that sped it up. We had basically made a decision to do it. And based on his care of that patient, we decided to recommend suspension.

DR. WALSH: Let me just add something here. You know, Dave's been here since 2002. I've been here since 1999. We've had residents who rotate through the ED and on other services the entire time. Periodically, people have different personalities, perhaps there's a dispute or that sort of thing with how a patient was taken care of and so forth.

And we try and interpret these things in context. And not every one of them was -- when we look into it do we necessarily concur with, and so we're not really -- we're not taking every single account at face value and not trying to look at the greater context.

But in both of these cases you have something where there is internally consistent accounts from the people who are present. You have something that disputes that and doesn't entirely hold water from Dr. Irani. And you have something that involves the quality of a patient's care.

And, really, the thing that showed up a number of times on his evaluations is this lack of empathy. And so in both cases here you have somebody who's been badly injured and the descriptions that we have of the behavior is that it was very casual and it didn't really seem to be compassionate for somebody who was badly injured.

MS. HILL: Okay, Dr. Koon, Dr. Walsh. Just a time check in. You have 20 minutes remaining.

DR. KOON: Okay. Page 47, that is a request for a psychological evaluation of Dr. Irani. We weren't sure as a faculty what was going on, and I asked the residents, you know, "Is there a drug problem? Is there an alcohol problem? Is there something going on at home that we need to know about?" And I asked them to check with Dr. Irani to see. Having heard the answer was no, the GMEC executive committee recommended a psychological evaluation for Dr. Irani to help assist the -- assist us in formulating his remediation measures.

Page 48 is Dr. Irani cancelled the appointment less than an hour before it was scheduled, having known about it for a week, because he was not feeling so great today and did not get sleep. So despite our efforts to get help for --

(File 2015 1 30 10 14 18(A) cut off)

(Beginning of File 2015 4 30 10 174 18(B))

DR. KOON: Dr. Irani states that he discontinued the grievance not to further jeopardize my relationship with my attendings. Again, I would note there was no attending pressure for him to discontinue any grievance. In fact, it's the exact opposite. We made him aware of it every time we turned around, that the appeals process is there for him.

And, again, one of the things that has been brought up numerous times is that this process was not punitive in

nature. These remediation measures were to get him back on track to finish his residency. And those -- that has been alluded to several different times in his -- in this documentation.

Dr. Irani, in those notes on Pages 51 and 52, notes that -- his familiarity with the grievance and due process policy. And, again, there's no mention of unfair or lack of due process.

Page 53 is Irani meeting with Dr. Walsh, and that's a Dr. Walsh memo where there's an extensive review of Irani's version of trauma female 375 -- her care. This was 12 days after the event, and he had the opportunity to give his side of the story to Dr. Walsh, the chair of the department. We again emphasized that remediation is to restore to your residency position, not as punitive, and that the GMEC functioned as our external review.

DR. WALSH: Let me just add one thing about the tail end of that discussion with Afraaz. You know, we've had any number of times where we have discussed things with him, where it's been formally, informally, one-on-one, a couple of people, in the hospital, outside the hospital, and so forth.

This particular time that he and I spoke, after -- I gave him the opportunity to go back through the entire -- his version of the issues with trauma female 375 and talked to him about accepting responsibility, having some insight, getting

used to the fact that he had to pay attention to what others said, and one of the phrases that Afraaz would commonly use is he would say, "I realize it doesn't really matter what I think. It matters what you guys think."

And the time I -- the first time I heard that I thought, well, okay, you know, he's beginning to understand that he needs to pay attention to the perceptions of others.

And then, as time passed, what I realized is, what he was basically saying was, it doesn't matter if I think you're right or wrong, I just have to respond to what you're saying. And the follow-up implication from that is, I think you're wrong, but all I have to do is kind of live with that.

And at the very end of this meeting that we had -- which I thought was very collegial; there wasn't anything combative about it whatsoever -- I said, "By the way, why did you cancel your psychological evaluation right before it was supposed to be done?" And he said, "Well, I was tired and I was a little concerned, wasn't sure how it was going to be used." And I said, "Well, did you call anybody?" And he said, "Well, I sent an e-mail to Kathy Stevens."

Well, I just -- I wasn't hunting for it. I just was aware that he had sent that actually after the fact. So I said, "So you sent an e-mail to her when?" And he said, "Well, Wednesday," or whenever it was, which was after he had cancelled the meeting. So in my conversation with him he is responding in

such a way as basically to try and trick me, and to say, yes, I sent an e-mail to Dr. Stevens explaining why I wasn't going to do it, when, in fact, he had sent it afterwards.

So I said, "Afraaz, you just did it. We sat here for an hour. We talked about things and -- about how you need to accept responsibility and so forth, and you just tried to trick me by telling me you had contacted Kathy Stevens prior to cancelling this appointment as opposed to saying, well, I didn't contact anybody, but I notified Dr. Stevens later."

So, again, it's an evasive way of responding to someone immediately in the context of a conversation about accepting responsibility and so forth. It was like he couldn't let it go to try and get out of something that he had done that was incorrect.

DR. KOON: Pages 54 and 55 are documentation that Dr. Irani made a misstatement to Dr. Stevens. He told her that he had scheduled an appointment with the -- for the psychological evaluation when, in fact, he had not.

Pages 56 and 57 are e-mail -- is an e-mail thread from -- to and from Dr. Irani and Dr. Stevens where Afraaz met with Dr. Stevens on the 3rd of January. He makes misstatements such as, "No one ever solicited my side of the story," which is patently false. Dr. Walsh did it less than two weeks after the fact. He said "never made aware of accusations against me," which, again, was patently false. Dr. Walsh provided those to

him. He said, "I was never involved," again, which is patently false. He was involved from the very beginning.

He also says that the same individual both times wrote complaints against him. Well, it was not the same individual both times. It was three different nurses -- or two different nurses and Diane Savage.

He then attaches his version of the encounter and forwards that to Dr. Stevens. Again, there's no mention of lack of or unfair grievance process.

Page 58 is an e-mail notification to Dr. -- to Afraaz with regards to the decision to uphold the recommendations. And, again, she states at the bottom of that, "This is to aid you in completing your training." So again this is not a punitive thing; this is our attempt to get him back on track.

Pages 59 through 68 are his psychological evaluations which were later included in his remediation measures.

On the 24th of January, Dr. Irani e-mails Dr. Walsh about the meeting that they had on the 24th, and there were some -- there's some disagreements about what exactly that meeting involved. And Dr. Irani takes Dr. Walsh out of context about the -- the recommendations that we sent to the GMEC are modifiable, and he notes that and that he is appreciative -- he looks forward to incorporating the feedback

of the department and becoming a better resident.

Page 70 is an e-mail from myself that we were going to meet with him on the 31st to go to the next step.

Pages 71 through 76 are a reinstatement of Level 2, so he's on -- he's been suspended over the holidays. He's back with us. And we met with him to review the new remediation plan. So he's going from a Level 3 to a Level 2. I reviewed his academic remediations there at the beginning. He handwrites in there on Page 71 that he attempted to appeal to the grievance council. He attempted to appeal after the time that was allotted for that, so he basically wasn't following the policy, so they did not grant him a grievance committee hearing at that time.

Again, these were faculty recommendations, not just one or two people. They were all approved by the GMEC executive committee. And the remediation plan was a very detailed plan that was a combination of faculty and resident input. And if you read that remediation plan, they're basic things that our interns and residents should know to do and should do them.

There wasn't -- there was no attempt to make these remediation measures so hard that he would never be able to complete them. These were very reasonable things like making the lists, reading and preparing appropriately for clinic cases, making the morning list ready. I mean, these are very, very black-and-white things that he should do.

We placed him on Dr. Voss' service because he was on Dr. Voss' service to begin with. He was on Dr. Voss' service to begin with, so we placed him back on the -- Dr. Voss' service. We had had problems getting our VA attending to complete timely evaluations, and we've had difficulty with him completing his requirements as set forth by the ACGME, so we thought it best to keep Afraaz on-site and under Dr. Voss' tutelage.

He signed Page 76 which called for immediate and sustained improvement.

On the 6th of February, Dr. Irani came back to work as a PGY 2. It was a very light week because most of us were gone to the academy.

On the 24th of February, Dr. Irani was involved in the care of a spine patient. And briefly, the patient was post-op day two or three from a very large decompression and fusion. That morning Dr. Irani did not document any type of neurologic testing or strength testing. Dr. Grabowski went and did it.

Later that morning Dr. Irani got notified that the patient had a foot drop, by the nurse. And the physical therapist had noticed that. So instead of being concerned, Dr. Irani asked the nurse to verify that foot drop in an immediately post-op patient. So -- right.

Dr. Irani then went up to see the patient, basically, appeared to lack concern for the gravity of the

situation. Still did not document his assessment. Called Dr. Grabowski, who went and evaluated the patient that way, ordered the MRI, and the patient was in the operating room that night to -- for a mass that was causing paralysis.

That Monday, Dr. Irani was with me in the staff clinic. He did a history and physical on a patient that had -- that was to have a total joint. He not only -- it was a very inadequate H&P. He didn't note that the patient had hepatitis C, which is very important from a surgical standpoint. He didn't note that the patient had an MRSA-positive history. He didn't note that the patient had chronic thrombocytopenia. He didn't note that the patient had psychiatric disorders. He noted no abnormal labs and no EKG.

Dr. Grabowski let me know about this in an e-mail, which is on Page 80. Dr. Grabowski and Voss met with Dr. Irani that Tuesday. And the very next day Dr. Irani was on call. He was asked to admit a patient with hemophilia who had a large swollen and tender calf. There was a concern that the patient had compartment syndrome.

Dr. Irani provided compartment measurements about midnight. Dr. Wood said -- told -- the chief resident said, "I want you to check the patient at four o'clock. If there's any difference I want you to call me, and then this patient may need surgery for a limb-threatening condition."

That -- the next day, Dr. Irani overslept, had to

actually be called by our chief resident to come to rounds. When asked what the evaluation was like at four o'clock, Dr. Irani looked at Dr. Walsh and said, "I forgot. I'm sorry."

DR. WALSH: Dr. Wood.

DR. KOON: Dr. Wood. He said, "I forgot. I'm sorry." He didn't do exactly what the chief resident told him to do, and had no excuse. He didn't say, "I checked the patient at 2:30." He didn't say that, "I checked the patient at 4:30." He said, "I forgot. I didn't do it." There's no documentation in the record that he ever checked the patient.

With these last two events, the department had no recourse but to recommend dismissal from the program. Dr. Irani was informed of this. And there are e-mail notes starting in 83, 84, and 86, documenting -- that mention Dr. Grabowski's e-mail, solidifying the fact that not only after he forgot to document all that, Dr. Grabowski told him, "Well, the drain got pulled out early. You really need to monitor the dressings." And Dr. Irani couldn't even do that, and had no excuse for that.

We notified Dr. Irani of these findings. We forwarded the departmental recommendations to the GMEC executive committee, who forwarded it. And these got approved on the 10th of April.

In the midst of his suspension without pay, there

was a very unusual request for Dr. -- from Dr. Irani for $800 of book money, in the middle of being suspended without pay. So our conclusions were that there had been repeated and documented substandard resident performances by many observers. There's been graduated levels of remediation measures used in accordance with the GMEC policy. There were both verbal and written, senior resident and attending interventions. And the -- it progressed from Level 2 to Level 3 twice.

There are documented attempts to get all the facts on each encounter. There are no allegations of a lack of unfair due process appeals procedures. In fact, we followed the GMEC policies to the tee. There's no allegations of Dr. Irani ever being singled out in any of his calls, letters, conversations, or e-mails. There's no allegations of unsatisfactory academic progress by -- from us to Dr. Irani.

Dr. Irani has never alleged inappropriate duty hour violations; the department using residents to fulfill service obligations. There's no allegations of us ever treating him differently from any other residents. There's no allegations of inadequate resident supervision. There's no evidence that he attempted to have his concerns by other committees -- and there's no evidence of anyone withholding information from Dr. Irani.

DR. WALSH: So, I guess, in conclusion, you know, Dave began this talking about when we interviewed Afraaz. You

know, here's somebody who's a smart guy, he's likeable, he has a record of success when he was in medical school. I interviewed Afraaz. I can remember the day that we were making the rank list that I was supportive of ranking him highly.

He starts here as an intern. We kind of hear some rumblings from other services and people that we trust, and there -- we don't necessarily trust everybody when we hear about it from other services. In fact, there's one particular attending that our residents used to rotate with years ago that we stopped that rotation because his evaluations were actually often incorrect, and it kind of was a waste of time.

But anyway, we're hearing the rumblings all the way along, and eventually he comes around to do his full-time orthopedic residency and, you know, there's this stack of paper. And keep in mind that nine-tenths of that is from July of last year through January. And so, you've got a very short period of time where he's making repeated, major mistakes.

The same theme is coming up over and over again about lack of empathy, lack of insight, lack of attention to detail, despite verbal and written counseling, informal talks, formal talks. Dr. Guy took him out to dinner one night at Harper's and tried to have sort of the "big brother, throw my arms around your shoulders" type of talk. And nothing seems to change at all.

So, you know, in the context of a situation where we

have feedback from nurses, from very experienced nurse managers who have seen many of our residents go by over the years, attendings from other services, orthopedic attendings, our residents, residents from other services, nursing staff that are in different parts of the hospital who -- one of whom knows Afraaz sort of on a slightly more social level, at least in context of professional interaction, but then also was party to one of these things that happened down in the emergency room, you know, we've got that backdrop.

Then we've got a situation where now we're talking about big patient care issues, the gentleman with the complex forearm injury, the female patient who had the ankle and the -- I forget what --

DR. KOON: Multiple --

DR. WALSH: -- multiple fractures. You've got Dr. Grabowski's patient who has a -- who basically has an acutely developing paralysis. It's happening right in front of everybody. And the initial response that the nurse told us when she called and said, "The patient has a foot drop" is that he said, "Aww, she has a foot drop?" in a setting where somebody -- I mean, this lady could've been paralyzed for the rest of her life.

That happens on a Friday. He's counseled on Tuesday morning, going over the details with Dr. Grabowski, who is the attending, and Dr. Voss. And the following day there's a

patient who has a limb-threatening condition and he doesn't show up, doesn't take care of the patient; that morning says, "Aww, shucks, I forgot."

When I talked to him about it the following morning, he says, "Well, actually, I did go by at 2:30, but I didn't document it." I have no way of proving whether that's right or wrong, but, once again, it smacks of evasive, defensive behavior. And I really can't tell if it's -- if it's the truth or not.

And at this point, there's just been a tremendous erosion of trust of all of the faculty in his ability to provide any type of reasonable care in that he's provided substandard or, frankly, horrible care for a patient of mine, Dr. Koon's, Dr. Voss', Dr. Grabowski's that are something considerably worse than a resident who was told to check the potassium and forgot and then made something up -- I mean, way, way worse situation.

Here's somebody who's only eight months into his residency. This isn't something where we feel like there's a salvageable problem. We've done every single thing we could because we wanted to make the most and restore him to the residency.

And, I mean, there's been other residents along the way who have had to, you know, kind of have the talk or -- with one attending, or perhaps in front of everybody. They've made

measures to correct things, and graduated as very highly successful residents. And here we just feel like we're getting absolutely nowhere. So that's what led us to the point of reluctantly but without apology terminating him.

MS. HILL: That concludes. Committee members, did you have questions now for Dr. Walsh or Dr. Koon?

UNIDENTIFIED FEMALE: Has he ever received a failing grade? I mean, (unintelligible) end of each rotation there's a different (unintelligible) pass or fail. (unintelligible)?

DR. KOON: Our evaluations are 1 through 5 --

UNIDENTIFIED FEMALE: Okay.

DR. KOON: -- and he really wasn't on our teams long enough without being on probation for us to ever really do that. So, no.

UNIDENTIFIED FEMALE: Is there an evaluation from Dr. Voss' recent three months with Dr. Irani?

DR. KOON: Yes, ma'am.

UNIDENTIFIED FEMALE: Oh, is it in here? I'm sorry. I saw the letter that he wrote. I didn't know if there was an actual evaluation from the three months that he did with him.

DR. KOON: If you look -- okay. So you're asking when he came back on the 6th --

UNIDENTIFIED FEMALE: Yes.

DR. KOON: -- was there an evaluation before he went back on Level 3?

UNIDENTIFIED FEMALE: Right.

DR. KOON: No, because Dr. Voss was gone the first week. And so he was basically only on service for those two weeks.

UNIDENTIFIED FEMALE: Okay.

UNIDENTIFIED MALE: It's a little hard to process all this at once, but could you --

DR. KOON: A little hard to get it in an hour, too, huh?

UNIDENTIFIED MALE: Yeah.

DR. KOON: I'm sorry.

UNIDENTIFIED MALE: Can you just give us an assessment of whether that psychological evaluation made a difference and what conclusions you drew from that, if any? How did that contribute to the process?

DR. KOON: There was --

DR. WALSH: I didn't think that it showed anything that was new that we haven't presented to you right now. I didn't see anything that there -- that I would consider a mitigating factor or something that would explain things at all. It just was basically more of the same.

DR. KOON: It did note that he was somewhat hesitant on his answers and that the final conclusion should be taken in that context, that he was a little bit defensive, which is kind of a normal thing. But he did say on Page 67 that they

recommended individual counseling. And this is worked into the remediation measures that we formulated after that.

And what we would have him do is go to E-Care, because you get four as an employee free. And so that was what we took from that. We didn't -- there was no DSM-R IV or V, whatever it's up to now -- there are no diagnoses that had to be acted upon.

MS. HILL: Do you need additional time to review or ask questions? All right.

Dr. Irani, do you have questions for Dr. Koon or Dr. Walsh at this time?

DR. IRANI: No, not right now. No, ma'am.

MS. HILL: Okay. If you're ready to proceed --

DR. IRANI: Sure.

MS. HILL: -- you have up to an hour to present.

DR. IRANI: I think we have some packets to distribute. I'll go -- can I get started, Lynn? Is that fine?

LYNN: Yes.

DR. IRANI: Okay. All right. Good afternoon. First, I want to thank everyone for being here on my behalf. Drs. Koon and Dr. Walsh, I've had the privilege of working with both of you personally. I know how busy both of your schedules are, so I do appreciate you being here. I know the rest of you are all very busy, as well. I know several of you had to make sacrifices to be here on my behalf, and I do appreciate that.

I would like to start off by saying that I am encouraged by the panel here today, that I am encouraged my grievance will be heard by a neutral third party.

I sit before you extremely concerned by the unethical behavior and the harassment I've been subject to at the hands of my program director and the chairman of my department.

I'd like to take a step back and start at the beginning. I arrived from the West Coast at Palmetto Health-Richland in 2010, excited to start my orthopedic surgery residency. What attracted me to this program was it was a small program and the plethora of opportunities to operate one-on-one with an attending physician. I felt this was an opportunity at hands-on training that you do not get in many other places.

However, my excitement was quickly suppressed. Six weeks into my residency, Dr. Koon called me into his office and told me that he was placing me on Level 2 remediation. He said he was placing me on Level 2 remediation. And in that same meeting he went on to boast about firing Dr. Chad Lamoreaux, a previous resident a few years ago, a few months before he was about to graduate as a PGY 5 resident. I was confused why he brought up this incident only six weeks into my residency.

Dr. Koon then handed me a letter with several deficiencies. And rather than going over them, he asked me to respond to them. Many of these were completely new to me and I

was admittedly confused. I went through them. I tried to reconcile what my interpretation of these events were with what was written. I asked Dr. Koon to elaborate on many of these, as I admittedly did not understand the majority of these complaints.

These were troubling allegations to me. I asked Dr. Koon for help. His response, "This just shows you lack insight," period. I was puzzled. How could I improve if I could not understand my own deficiencies? I was left to conclude that the true motive at this early stage was to set the groundwork for termination.

Attempts at further clarification were simply met with the response, "Look, we get the best residents. The surgery program would be happy to trade three of theirs for one of mine. The medicine program here is happy to get somebody that speaks English. We get the best residents."

It was clear I could not get any more clarification at this meeting, but I took these allegations seriously. I did everything I could to understand how I could improve. I wanted to do whatever I could to correct these alleged deficiencies. Having no guidance from my program director, I reached out to my fellow residents.

One statement in the remediation letter said I created more work for my resident peers. I spoke to each of them individually and privately. They all individually and

privately denied this, and went so far as to say that I went above and beyond what was required of me.

In fact, there was no secret we often violated duty hours, myself regularly going over the 80 hours a week mandate. From talking to my program director, my fellow residents, the response was always, "Make it work." Indeed, the program is currently under investigation by the ACGME for, amongst other things, work hour violations and lack of resident supervision.

The letter also alleged I did not appropriately treat pain in a trauma patient. I pointed out that on this particular patient I was not the primary team, nor did I do a reduction. This was all done by my attending. So I did not cause the patient the excruciating pain alleged.

In fact, I saw the patient a couple of days later on the floor. He shook my hand. I asked him if he remembered me, and he volunteered that he remembered me from the emergency department. He thanked me personally and said how happy he was with my care. I think the ultimate judge of compassion and care should come from the patient. This patient remembered me and was pleased with the care, albeit he was very disappointed with his injury.

I did, however, take away that I should work on improving how I present myself in front of my peers. However, I think these events as presented to the GMEC were grossly overstated at best, and at worst frankly false.

Lastly, Dr. Koon at this meeting gave me his personal word that these events would be kept private between Drs. Koon, Dr. Walsh, and myself. Needless to say, this was not true. I was very disappointed when my chief resident began asking me if my decisions were okay given that I was on probation. The faculty and my fellow residents somehow all came to know about my inadequacies without me saying a single word. Clearly, Dr. Koon's personal promise was empty. It seems the goal here was to publicly humiliate me rather than support me.

Despite these allegations not being explained or substantiated, that did not stop them from presenting these statements to the GMEC, for them to base their decision on voting if I was to be placed on Level 2 remediation. This experience was disenchanting, confusing, and disappointing. It was especially disappointing to be placed on probation six weeks into my residency. What made it more frustrating was I could not get any guidance, feedback, or direction from my program director.

It became clear that I had to become extremely defensive if I had a shot at surviving. Despite all this, I reevaluated where I was in my training and my ultimate goal of becoming an orthopedic surgeon. I recognize I am not perfect, and, like all residents, I have had my share of mistakes. But I felt that I was not given much guidance. And I went out of my way to figure out how I could improve. I racked my brain to

figure out why I was being treated like this.

In retrospect, there was a troubling pattern of behavior from my residency director that I tried to laugh off that would become more and more of a problem. Dr. Koon continued to escalate in trying to derogatory -- making comments, saying I was a terrorist, going so far as to label me Achmed the Terrorist.

While I found his comments terribly insulting, terribly unprofessional, and terribly insensitive, I quickly realized as I had been instructed by my senior residents regarding conflict with an attending, that responsing (sic) -- that responding only makes things worse; in this program, grin and bear it.

I decided to try and extract as many learning points as possible from this experience. I decided I needed to improve on my communication. I decided to accept the probation and move on. I was excited to come to work every day, and realized the best thing I could do towards reaching my goal of becoming an orthopedic surgeon was continuing to work hard and improve in the eyes of my attending.

On October 26th Dr. Koon told me there was some issues with my performance. I asked him what the issue was. He simply said, "Speak with Drs. Wood and Dr. Mazoue." I spoke with them individually, and they said they had no complaints. Indeed, this was in line with my usual feedback from Dr. Koon,

consisting of vague, negative comments, lacking direct directions for improvement, and ultimately unsubstantiated. These feedback sessions were becoming frustrating and taking a toll, as I began to wonder what I was doing wrong and right, at the same time afraid of being punished for doing anything right or wrong, and often frozen in indecision.

In early November there was a VA patient that was transferred to Richland. The patient was lacking a dictation. This got routed to Dr. Koon. Dr. Koon routed it to me. A few days later, he asked if the dictation was done. I informed him that it had not shown up yet, but as soon as it shows up in my inbox I would take care of it.

That evening a dictation showed up in my inbox for a VA patient for an H&P. I took care of it. Dr. Koon texted me a few days later asking about this. I told him I took care of it. After a few rather confusing text messages, we got on the phone to figure out there was actually a second VA patient. I took down the name and investigated the patient.

On examination, I actually -- I'd actually never been involved in this patient's care. I dictated the discharge summary, as asked.

Worried that this miscommunication might create more issues and knowing that Dr. Koon had repeatedly emphasized my need to over-communicate, coupled with prior allegations that I was creating more work for others, I sent him an e-mail telling

him everything I knew about the patient -- who was involved, the time of the patient's admission, and that I had completed the task as assigned so there was no miscommunication this time.

I believe I was doing my best to improve and correct the deficiencies my attendings had perceived. However, this attempt at trying to follow my remediation plan and ensure proper communication was not taken well by Dr. Koon. Dr. Koon responded to my attempts at improving communication, as can be seen in Exhibit F of your binder, by writing, "Absolutely incredible. I can assure you I would never in a million years send a response like this to my program director, especially when I am in the midst of active remediation." He expressed surprise and indignation, and called my e-mail "drivel."

Dr. Koon became so enraged he was "unable to speak to his wife." He further boasted to me that the e-mail he sent me was actually "significantly toned down" and the original had much stronger language. He then openly threatened, "You were lucky you were on vacation because I would have fired you on the spot." Indeed, he finally admitted his true intentions to me.

In the weeks that followed, there was a much more sinister turn of events. At our meeting on November 21st, he now recommended that I be placed on Level 1 active remediation, when my probation was up on the first week of December. I asked for clarification. He could not cite any deficiencies regarding the remediation plan. I was encouraged to hear that I corrected

the deficiencies outlined in my remediation.

He therefore began to cite events that had happened before I was placed on remediation, from back in June and July, issues that had long been resolved. Interestingly, if these were true issues, I was curious why they were now being brought up now, and not in my initial feedback, back in August. It seems things had turned into a fishing expedition rather than truly identifying faults and ways for me to improve as a resident.

His about-face showed re-doubled efforts to vilify rather than educate me. Indeed, the most surprising factor was a mere one and a half weeks later after that meeting, he somehow changed his recommendation from Level 1 to Level 3 remediation, with suspension of clinical duties.

Dr. Koon invited me to attend the faculty meeting when I was scheduled to be done with my remediation. At this meeting, I was shocked by the confrontational tone of this meeting. Dr. Koon questioned me in front of the entire faculty, challenging me, "Do you think it was a wise move to take vacation during your remediation?"

I had carefully scheduled my only two vacation days to coincide with the vacation days of my attending, so as not to create more work for the rest of my team. Since I had started my PGY 2 year, I only took two days off to see my family. I have no family in South Carolina. And I went to visit my family

and my newborn niece.

Dr. Koon insinuated that I did not take the probation seriously. I found this insinuation terribly insulting. In fact, I missed my very own brother's wedding so I could be on call over Labor Day. I knew that if I requested those days off it would cause further work for my fellow residents, and I was striving to improve on the allegations that I was perhaps creating more work for other residents. That was how seriously I took my probation. I missed my brother's wedding rather than risk upsetting Dr. Koon by taking Labor Day off.

The insinuation that I did not take my remediation plan seriously and frivolously took vacation days off was hurtful, uncouth, and uncaring.

I had personally spoken with Dr. Stevens and Dr. Koon about my two vacation days. He had personally signed off on it. I had done my best to clear it with everyone. Again, I was in a situation where I am so afraid of being punished for doing anything, right or wrong, that I often don't know what to do.

Dr. Koon went on to reference a patient that had been in clinic and seen by me. My attending, Dr. Grabowski had asked for an MRI to evaluate the patient for possible infection. He was status post several months an ex-fix removal of his right upper extremity.

I was told by ancillary staff that one could not be scheduled that day, and the next available spot was the next day. I preliminarily asked them to schedule the MRI for that day, and went back to the room and talked to my chief resident.

My chief resident instructed me to call radiology personally, which I did. I got the MRI scheduled that day. At that point, I returned to the patient's room and I sent him across the street to get his MRI taken. To my understanding the care plan was carried out exactly as my attending Dr. Grabowski had requested.

Dr. Koon was not present during the care of that patient, and relied on secondhand information about this patient. I had no complaints about the patient's care, and indeed it was carried out exactly as my attending wanted.

Rather than asking me for details about the incident, Dr. Koon invited me to the faculty meeting and incited me in front of the entire faculty. He declared that I came up with the plan in direct conflict with that of my attending. He stated I planned to get an MRI in two to three days, and stated that was a decision I made as a PGY 2 when my attending had told me differently. He went on to provoke me by saying, "I am wondering why you thought it was in your purview to contradict your attending's recommendation."

I was taken aback by the statement, frankly

confused, obviously flustered, when to the best of my understanding my care plan had not deviated from that of my attending.

Moreover, Dr. Koon was not present. He relied on secondhand information, and never asked for my side of the story, and authoritatively declared that I had contradicted my attending's recommendation. Moreover, this was the first I was hearing about it. If there was a problem, I should've been asked beforehand.

The allegation here was that if there wasn't an MRI scheduled until the next day, I should not even have bothered to schedule that. Again, the line between what is right or wrong seemed to be a moving target, and I became more confused and increasingly worried about the discipline for minor infractions. The patient had received the appropriate care that my attending had outlined.

If the goal is to educate and support residents, I believe I should've been afforded the common courtesy to explain what happened, since Dr. Koon was relying on secondhand information and did not have firsthand knowledge of the events. Instead, he asked me to respond to an inflammatory, incorrect accusation in an obviously confrontational manner.

It was clear I had no ground to stand on, as Dr. Koon had verbalized. His goal was to fire me, and fair hearing and proper representation of the facts would not get in his way.

Indeed, as one of my co-residents wrote in an unsolicited, confidential e-mail, "I feel this is more of a witch-hunt than anything."

It was clear that my superiors were not interested in my education. They were, rather, working towards Dr. Koon's openly declared goal of firing me.

Dr. Koon made two more points in front of the rest of the faculty, attempting to degrade me. He alleged improper dosing of narcotics. This was a non-narcotic naïve patient who was post-op day zero, status post shoulder surgery. She had no weakness, paresthesias, or mental status changes. I okayed 5 milligrams of oxycodone, more than Dr. Mazoue gives his narcotic-naïve post-op shoulder patients. Dr. Koon repeatedly cited this as substandard care, again, bringing it up in front of myself and the faculty in February.

I asked what I should've done differently. Dr. Koon asked Dr. Hoover, our chief resident, what he would've done. Dr. Hoover replied that he would ask the patient if he had any weakness, paresthesias, or mental status changes, and if the patient didn't, he would have okayed more narcotics. I was stunned. The same treatment plan said by my colleague became inappropriate management when spoken by me. Again, I felt constantly intimidated by my attending, calling me a terrorist and threatened with discipline for minor infractions but for which he gave a pass to other residents who had done the same

thing.

Again, I found myself in a situation in which I'm being afraid of being punished for doing anything right or wrong, and I'm unclear what to do.

Dr. Koon additionally asked why I failed to evaluate a post-op total knee patient. This was a patient who had called the previous Saturday. She told me a scab had fallen off her knee and there was some drainage. I told her with these exact words, "Ma'am, I cannot tell you anything about your wound without taking a look at it." And I encouraged her to come to the ED.

She called twice again the next day with a different resident. That resident told her the same thing. I conferred with that resident. We both told her to come in. She was told once by me, twice by the resident the next day. She did not show up at the emergency department.

Despite two residents who both told her to come in, the patient did not follow these instructions. Dr. Koon lambasted me in front of the other residents and faculty simply saying a patient called three times and I had told her not to come in, which is frankly untrue.

At the conclusion of this, I insisted that there be a way to document our phone calls, since no such system was in place and since it was clear Dr. Koon placed no value on the veracity of any statements, and it was increasingly clear I

needed additional safeguards to protect myself.

Lastly, Dr. Koon, in front of the orthopedic department staff, made the allegation that my poor behavior was a pattern. He stated he heard similar complaints about unprofessionalism and poor patient skills about me from the trauma case managers. I was puzzled because I had received positive feedback from them. However, I wanted to understand how I could become a better resident.

I approached them again. I spoke to them individually and privately and asked what they thought. They frankly denied such claims. They said they were pleased with my performance, and emphatically stated they enjoyed working with me. Again, I was confused, in a situation in which I was so afraid of being punished for doing anything, right or wrong.

Indeed, it was clear that Dr. Koon was more intent on slandering my name in front of my peers and my attendings, irreparably harming my name and my reputation. The faculty meeting concluded.

Later that week a multi-trauma came in at 11:00 a.m. She was seen and evaluated by our orthopedic intern. The intern called the chief resident, Dr. Wood, saying that it was a particularly sticky situation and she needed help.

Dr. Wood directed her to call me, a second-year resident on probation, to supervise the orthopedic intern in a sticky situation in the emergency department. I received a page

at about 2:00, 2:30 p.m. I immediately informed my attending, then went to the ED to help out.

I arrived to a situation of frank disarray. The patient was now three and a half hours her initial -- after her initial trauma. She had been moved out of the trauma bay and still had open, displaced, and non-treated fractures. The patient and nursing staff were understandably upset.

Before I had even seen the patient, the nurse clearly and, again, understandably upset, said, "We need to talk about how all this was handled." I asked her what happened, what I could do, and what needed to be addressed. She simply said, "We will talk about it at the end."

Having gone through this experience with these nurses before, I toed the line. I did my best, went out of my way to please all parties involved. I introduced myself to the patient. I described all injuries to the patient. I assessed her pain. I talked to neurosurgery who told me they could not do conscious sedation. I then went and gave local and systemic anesthesia before performing any reductions.

I talked to the family personally. I brought the family back personally to the emergency department, where I showed them all the injury films on the PACS station. And then I helped the nursing and ancillary staff, including cleaning up and helping them change all the wet sheets on the bed.

That Friday I received a phone call from my

chairman, Dr. Walsh, who said there was an incident involving a trauma female that I took care of and I am being suspended so that an investigation can be performed. Dr. Walsh assured me the purpose of the suspension was to get all sides of the story "including yours." This turned out to be false. I was shocked, saddened, stunned at the events that transpired next. No one talked to me. No one attempted to contact me. No one was even interested in hearing my recollection of the events.

To add insult to injury, I received a phone from our program director, Michelle Wehunt, saying that there was a letter for me. The letter was a copy of the GMEC recommendation for Level 3 remediation. It had already been submitted and already been approved by GMEC. I was floored.

No one contacted me about what happened with trauma female, as I had personally been promised by my chairman. And my program director who performed the investigation didn't even have the decency to call me and inform me of his decision or thought process, but rather had his secretary give me a call to pick up a memo that he had already turned over to the GMEC.

This was the ultimate slap in the face and lacked common human decency and courtesy. It was now abundantly clear that Dr. Koon and those entrusted with my education had made no attempt to and were not interested in ascertaining the veracity of statements that were presented to the GMEC. Most glaring were the frank falsehoods presented to GMEC, statements that

constituted frank libel, notably neglect of informed consent. This allegation is false on many different levels.

First, no resident, no resident -- none of our residents in our program get consents for emergent procedures. Furthermore, this discussion with nursing staff was broached to the orthopedic intern before my arrival, three and a half hours after -- three and a half hours after the initial trauma. Simple fact-checking, following standard procedure, or having the professional courtesy to call and talk would have avoided such deceitful and libelous comments presented to the GMEC.

Similarily (sic), other statements about improper pain management are untrue as I gave both local and systemic anesthesia prior to manipulation. I assessed the patient's level. I went to the additional step of talking to Dr. Toussant from neurosurgery, who told me conscious sedation was not an option.

Moreover, as presented above, allegations of inappropriate narcotic dosage and failure to evaluate a post-op knee were gross overstatements of the truth, and actions that were either substantiated or performed in the same manner by my colleagues. Similarily, as described above the statements that I failed to abide by direct attending instruction is a perversion of the facts.

What was surprising was that my superiors had violated Palmetto Health's own written and stated guidelines.

In the resident handbook, Page 61, which can be seen at Exhibit R, it cites disruptive behavior as inappropriate conduct that reflects in a negative way on a hospital or university. It then clearly states under "procedure," also under Exhibit R, the program director or designee interviews the complainant and any witnesses within one business day of receiving the complaint. A resident is given the opportunity to respond in writing (audio cuts off; end of File CD 2)

DR. IRANI: Most stunning, and what I find very unusual, were all three of Palmetto Health's own guidelines were violated. I was never interviewed. All witnesses were not interviewed, despite my providing names. I was never given the chance to respond, period.

The fact that no one bothered to ask for my side of the story was not only horribly unethical, hurtful, but lacked common courtesy and respect that I would think everyone, let alone physicians, should practice.

By this point Dr. Koon had successfully turned all popular opinion against me. I was still honestly confused about the situation and wanted to understand how I could improve. Just as I in the past made progress on my remediation goals by doing investigation myself, I attempted to do the same thing here. I asked what the complaints were, who made the complaint so I could speak to them, and for a copy of all records associated with the patient's care so I could understand what

exactly was alleged and how I may improve.

Despite repeated verbal and written requests as can be seen in Exhibit K, to understand and get a copy of the complaints against me so I can improve, my request was denied. I initiated a request with HR to initiate a grievance council meeting regarding my suspension within ten business days of the DIO's decision as outlined under grievance and due process in the resident handbook, which can be seen in Exhibit Q under 1.5.

Since Martin Luther King Day was a national holiday, the banks, offices, post office, and most importantly the orthopedic surgery clinic closed, it was logical not to count MLK as a business day.

I was shocked when they refused to grant me a grievance council, saying that 11 business days had elapsed and that MLK Day is not a holiday. I pointed out that to my understanding MLK is a national holiday; furthermore, there's a discrepancy -- a business day is not, to my knowledge, defined in the resident handbook, a fact that Kathy Stevens herself later conceded.

Moreover, should there be any confusion about the deadline, the resident handbook makes explicit provisions to extend any deadlines due to extenuating circumstances. I was denied due process despite the fact that I made a good-faith effort to follow the guidelines laid out in the resident

handbook and filed my request within ten business days as outlined in the resident handbook.

It appeared the primary motive here was not to act in the resident's best interest, but rather play "gotcha" with our careers, a career I've worked my entire life for, and something I would hope would garner more respect and understanding from those charged with graduate medical education.

To add insult to injury, I received an e-mail shortly thereafter requesting me to come in and write a check for a paycheck that was accidentally paid to me during my suspension. At this time, I expressed serious reservations about my treatment and the fairness I was receiving from my program director, and I sought counsel elsewhere.

I spoke with Dr. Guy. I appreciated his feedback, found I made much more progress speaking with him. I asked him if he could oversee my remediation plan so I could get more guidance, since I felt I was not making much progress with Dr. Koon. He stated he would be willing.

As seen in Exhibit N, I proposed Dr. Guy oversee my remediation and progress, as I had reservations about how I was being treated and felt I could get much more constructive feedback to help me become a better physician with Dr. Guy overseeing my remediation plan. This request was summarily denied by Dr. Koon.

Despite the failure of due process, violation of Palmetto Health guidelines, and the presentation of false statements to GMEC, Dr. Koon successfully had me suspended from early December to the end of January. This was embarrassing, humiliating, demeaning, and was done in violation of professional and Palmetto Health guidelines.

I was reinstated in the beginning of February. At this time Dr. Koon handed me a letter placing me on Level 2 remediation. What was interesting was a now greatly expanded list of deficiencies. I was taken aback by now the laundry list of competencies not being met under Exhibit O. I had not been on service since my previous evaluation placing me on Level 3 remediation, yet somehow my list of uncompetencies had somehow exploded.

Notably, things that I had been told were never issues were now listed as competencies not being met, including complaints about my knowledge base. I had never been told my knowledge base was lacking. In fact, Drs. Walsh, Mazoue, and Guy had all explicitly told me my knowledge base was fine, better than average. Excuse me. My in-training results substantiated this and easily outpaced that of my PGY 2 colleague. This was alarming to me, and it was apparent Dr. Koon's goal was to list as many competencies as deficient so should I make any misstep he can more easily fire me.

The goal here, it seemed, was not to provide a

framework for remediation, but rather, again, continuing to play "gotcha" with my career. Once again, here was something I had been told I was doing well in, and again I was in a situation in which I was being punished for doing anything, right or wrong.

Lastly, I noticed that Dr. Koon and Walsh had changed my schedule. I was scheduled to be rotating at the VA and Baptist Hospital. However, these rotations that all the other residents partake in were removed and I was assigned to the Richland service, again on service with the same attendings I had just rotated with. My education was further compromised as I did not have the opportunity to have someone else supervise me or serve in a mentorship role.

However, I redoubled my efforts and was genuinely happy to be back. In February, after I finished the two-month suspension, I was willing to work to correct any legitimate deficiencies, and again earnestly strived to show that I was serious about the comments that I had received and my education.

I started back on Dr. Voss' service. I wished to show I was indeed a team player, and took the initiative and decided to adapt and create a resident step-by-step guide with step-by-step directions, pictures and figures about how Dr. Voss performs his total knee arthroplasty. I thought this would be an invaluable tool to residents coming after me. I worked hard to correct these perceived deficiencies in my performance.

On the evening of March 1st, Dr. Koon called and told me that I was again suspended, and he was recommending me for termination regarding my care of two patients. A hemophiliac patient was admitted at approximately midnight for observation for possible compartment syndrome.

I did an interval examination at about 2:30 for compartment syndrome. The examination was unchanged. And as I was seeing another patient, my exam was unchanged from before, I decided to treat the current patient in an expeditious and caring manner. I put in a note on the patient within 48 hours of seeing the patient.

Dr. Koon also mentioned the issue with a spine patient with neurologic changes. I saw her as soon as the nurse told me that she saw neurologic changes. I examined the patient as soon as she was available, and called my attending as soon as my exam was done.

My attending, over the phone, told me my physical exams and findings were inaccurate and incorrect. Accordingly, I could not document my findings as I had been directed by my attending that my exam was inaccurate. I had been directed previously by my attendings to not document inaccurate findings in the patient's chart.

It is also noteworthy that this was my very first spine patient as a resident, and there was no senior on the

resident service with me.

When confronted about these patients, I followed the remediation plan which directed me to "admit and apologize for mistakes and be willing to endorse personal flaws." Therefore, when confronted about these patients, I immediately apologized. I said that I would do better next time. I did not make any excuses and listened to what was said.

While I admit that I have made mistakes, both patients were evaluated. It is also noteworthy that I had just returned from a two-month hiatus and was unsupervised on service. I learned from these experiences that I still need to work on improving my efficiency.

Again, I believe these are all examples of resident education. While I believe there is always room for improvement, mistakes, feedback, and resident supervision are all integral parts of resident development. It has been hard for me to focus on learning and my education with the stress of this unmerited treatment.

Through the entire process, I've been illegally targeted. I have been vilified for activities that my colleagues have not been penalized for. Standard hospital policy has been ignored. And my name and reputation have been subject to libel and slander by Drs. Koon and Walsh in front of the GMEC committee and the hospital staff.

They misrepresented me to the Graduate Medical

Education Council. I believe that GMEC's decisions were based on false information and malicious misrepresentations.

Lastly, and perhaps most importantly, I have had more stress placed upon me when dealing with patient care by having to undergo derogatory, inappropriate, and insensitive racial taunting by those entrusted with my education.

While on remediation, Dr. Koon regularly taunted me, calling me Achmed the Terrorist. While I tried to laugh it off, these comments are deeply harmful and insensitive, given the past history of religious persecution of those of my people and the recent terrorist attacks in Mumbai, India, where my family resides, and the impact these cowardly attacks have on my immediate family.

The pattern of singling me out and open slander and libel in presenting my case and racist behavior is incongruous with someone entrusted in the role of an educator. Moreover, at least five of these deficiencies cited here were either performed or verified by my resident colleagues without retribution, including treatment of trauma female 375, dosing of narcotics, medical knowledge, evaluation of post-op knee, and wound closure.

I felt constantly intimidated by Dr. Koon, either calling me a terrorist or threatening me with discipline for some minor infraction, but for which he gave a pass to other residents who had done similar things.

I was frankly in a situation where often I was afraid of being punished for doing anything, right or wrong, that it was not clear what I could do to avoid punishment.

I believe I'm a friendly person, but cultural differences and insensitive behavior have made it hard to focus on becoming a better physician.

I admit, I may appear differently. I might act differently. I'm new to the south. I was born and raised in California. I completed my undergraduate and medical school education at Stanford University on the West Coast, in an environment quite different from my current setting. I don't think it's the responsibility of others to understand my background, but I think they should at least be accepting.

I readily admit that I have made mistakes, like all young physicians, and want to change in a way that will make me a better doctor. Indeed, each time I was placed on remediation, subsequent evaluations largely validated that I addressed or improved upon my remediation goals set forth.

I want to do better, and indeed I've strived hard to do so, talking to others and soliciting feedback where this was missing from my program director. But in order to improve, I need a clear definition of mistakes and how I may improve.

I'm shocked by the callous nature and actions of my department. Decisions like this have derailed my entire career, and should at least be subject to due process. My name has been

slandered, and it's extremely difficult, if not irreparable, to fix. My name is my profession as a physician, and it has been unjustly tarnished. What job prospects do I now have in this area?

In summary, I have attempted to bring my concerns before the appropriate local committees, but I've been disappointed by their unwillingness to listen to my grievances, and believe I have been denied due process.

Additionally, I have been subject to racially based harassment by my program director, and I've been singled out for disciplinary actions for minor infractions. This pattern of behavior has been evident throughout my PGY 2 year and my program director who repeatedly calls me Achmed the Terrorist, and makes constant insinuations about my cultural background, repeatedly submitted documents to GMEC that are patently false in order to attempt to demonstrate a pattern of unsatisfactory behavior on my part.

He placed me on probation only six weeks into my PGY 2 residency based on several unsubstantiated allegations. Requests for clarification of those allegations were denied, and I have been unable to get any independent verification of these allegations.

My program director has gone out of his way to attempt to discredit me in front of other faculty members, alleging improper care despite clear evidence to the contrary,

including from other faculty and residents. He has further alleged deficiencies in my knowledge base, despite evidence to the contrary. My training scores outpace that of my fellow resident. Needless to say, such constant harassment makes it nearly impossible for me to focus on my education and my patient care.

My program director is continuing to present false statements to GMEC. For example, in one case, he alleged improper care of a trauma patient. I was not involved in that patient's initial resuscitation, but was called to assist after the patient had been in the ED for over three hours.

Many of these allegations did not involve me at all. My program director refused to ask for my side of the story, in complete violation of and in complete disregard for the hospital's policy. He turned over factually incorrect complaints to the GMEC for my suspension. I was denied fair hearing and due process. Most egregious were the multiple times I asked for documentation of the allegations of poor care, and they and Kathy Stevens refused to turn over these documents.

I have, each time, protested to Kathy Stevens, but to no avail. In fact, my previous request for a grievance council was denied.

Additionally, I was denied the chance to engage in regularly assigned rotations at the VA beginning in January, and this prevented me from being educated on a rotation that all

other residents are assigned to. It also denied me the opportunity to get an unbiased evaluation of my performance by the orthopedic staff at the VA.

It is noteworthy that this program has an attrition rate well above the national average, taking only two residents a year, the smallest in the nation, and now potentially losing a third resident in the past four to five years, a fact they seem proud of, and my program director emphasized only six weeks into his residency -- my residency.

The actions of my department recently culminated with them moving for my termination. I am very disappointed and concerned, since their behavior has been unethical, deceitful, and illegal. I am not confident in the checks and balances of the hospital when the department chairman and program director can regularly violate hospital policy and when my chairman assures me of the outcome of a GMEC meeting before any proceedings have ever occurred.

Importantly, it is noteworthy that this program is currently being investigated by the ACGME for work hour violations and lack of resident supervision. I implore you to help me in this situation. Please help me get due process and investigate this pattern of targeted unfair behavior. I have worked hard and sacrificed much to become an orthopedic surgeon, and I feel that those entrusted with my education have reneged on their commitment.

Thank you.

MS. HILL: Committee members, do you have questions for Dr. Irani?

UNIDENTIFIED FEMALE: Dr. Irani, how would you address the contention that you've been repeatedly counseled and you've failed to make any change in your behavior?

DR. IRANI: Well, I think the one point that came up with the evaluation of my intern year -- and you saw the selection of them -- those were all in the first half. And Dr. Jones and Dr. Bynoe, I think, were correct. I was new to the area. And I met with them. They gave me very good feedback. They said, "This is, you know, how you present yourself. This is how you come across."

And their subsequent evaluations showed marked improvement, and I was able to make progress. I think that conversation was one of the best I've had in terms of feedback. And I've never gotten that -- once I started orthopedic surgery, all I got was it shows you lack insight, and I wasn't given any guidance about how to do that. And so I did have some issues initially, but the -- and the reviews all showed improvement towards the end of my intern year.

UNIDENTIFIED FEMALE: Do you have any doubt about your choice of orthopedics (indiscernible) profession?

DR. IRANI: No.

UNIDENTIFIED FEMALE 2: I have a question.

DR. IRANI: Sure.

UNIDENTIFIED FEMALE 2: This memorandum that was dated August 15th --

DR. IRANI: Is that in --

UNIDENTIFIED FEMALE 2: It's in -- you both actually have a copy of it.

DR. IRANI: Okay. Okay.

UNIDENTIFIED FEMALE 2: But you said a couple of times that you felt like you weren't given any specific mentions of where your deficiencies were or what you could do to improve them, but this outlines pretty well, in my opinion, you know, what they felt were your deficiencies and the measures that you should go to try and improve those things. Did you not feel like that that was adequate, or how would --

DR. IRANI: So are you talking about the initial letter -- August 15, '11?

UNIDENTIFIED FEMALE 2: Yeah.

DR. IRANI: So --

UNIDENTIFIED FEMALE 2: What would you have added to that to make it more clear? What did you feel like needed to be added to it?

DR. IRANI: Sure. So, you know, first of all, if you look at stuff like, "He has repeatedly demonstrated poor time management, frequent tardiness, required conference, clinics," I was not aware of that. I asked for specific

examples. I was not provided any, but I decided I would work on it.

Poor communication skills with patients, family, peers, and attending physicians, again, this was the first time I'd heard about it, so I said, "Where is this coming from? I haven't had anybody tell me this before. Could you please tell me what I'm doing wrong? How am I going to improve?" Again, "It just shows you lack insight."

Effective prioritization of clinical duties, these are all very broad statements. Actually, some of this, what I'm hearing today, I'm hearing for the first time. I was not provided any clarification. I asked them -- I went to each of them and I asked. I was not provided any -- how I'm not performing well in my clinical duties.

Additional duties for other residents, I took this one most seriously, and I asked what he was -- what I was doing, how was I creating -- what had I done wrong. I got no examples from Dr. Koon. And that's when I spoke to each resident individually and privately, and a lot of them said I go above and beyond.

So, you know, those are the examples. You know, substandard evaluation, we talked about that. I think I showed improvement throughout the way.

And lack of attention to detail, so that was never laid out, where that came from. I got no feedback. I went and

talked to the OR staff to try and get some feedback, and that's how I was able to determine anything at that time.

So I think the broad statements, it's the first time I'm hearing about them. They're not explained to me where they came from. There are no examples given. And maybe -- you know, maybe I do lack insight, but if that's the case, I think I need to be shown how I can improve, and that effort was not there.

UNIDENTIFIED FEMALE 3: Can I clarify something?

DR. IRANI: Sure.

UNIDENTIFIED FEMALE 3: One of the patient anecdotes -- and we've gotten into some pretty detailed discussions here -- I think it's the hemophiliac where there was a question about compartment syndrome.

DR. IRANI: Yeah.

UNIDENTIFIED FEMALE 3: You wrote that you went back and wrote a note within 48 hours.

DR. IRANI: Right.

UNIDENTIFIED FEMALE 3: Do you think that was a reasonable time period?

DR. IRANI: I think -- I evaluated the patient, but, as I said, I think I -- I should've put it in right there. I should've stopped with the patient and moved on to it.

UNIDENTIFIED FEMALE 3: Have you admitted that to anybody?

DR. IRANI: Yeah. The very first time I met I think

I said, "Here's where I went wrong." In my initial meeting, I think, you know, Dr. Koon said I admitted I made mistakes. And this time I just said, "Yeah, I should've just written -- stopped what I was doing right there, but I thought I'd bounce back and do it again." But that was probably not the best move. But I think the -- I did evaluate the patient and I put the note in afterwards.

UNIDENTIFIED FEMALE 3: You do understand the importance of that note?

DR. IRANI: Right. Yeah.

UNIDENTIFIED FEMALE 3: So they would argue that they've tried to point this sort of thing out to you and nothing really changes. How would you respond to that line of -- or that sort of accusation?

DR. IRANI: The accusation with response to the hemophiliac patient?

UNIDENTIFIED FEMALE 3: Well, in general that notes not completed on time or your H&Ps -- Dr. Walsh alluded to the fact that repeatedly where he explained (unintelligible) --

DR. IRANI: So -- so -- yeah.

UNIDENTIFIED FEMALE 3: -- missing.

DR. IRANI: So those are specific examples. And Dr. Walsh himself admitted this. This was the last week of my rotations was when he finally sat down and went over the H&Ps. The H&Ps have specific things about -- there's a preoperative

slip, and for a given surgery you've got to put length of surgery, you've got to put what pre-op labs, what equipment.

And I can do stuff -- like a carpal tunnel, I know that. We've done a bunch of them. I know all the equipment; I know all the time; I fill it in. But when it's something like a tendon transfer, I fill out the name of the procedure. I don't know how long it's -- because I've never done this before, so I'll leave that blank. So there's skips.

And I asked the -- his secretary what to do, and she just said, "Oh, Dr. Walsh fills in what you don't know at the end." So what I would do is I'd fill in as much as I would know. And that's why some of them would be complete -- carpal tunnels, I can do that -- some of them are not complete. I don't know what tray sets you do when you do a tendon transfer and you do something else.

And, again, this conversation happened the last week of my rotation with Dr. Walsh, and he actually -- I didn't know -- there's one form that goes to the scheduler, one form goes to Richland, one form goes here. Nobody explained that to me. And he admitted himself that he had never broken it down for me.

But once I think he explained it, I got some insight into that. But I think that would explain the perception that I was jumping around, was the fact that I would just fill in what I knew in some cases and others I'd leave blank. And I was told he'd fill them in at the end of the day.

UNIDENTIFIED MALE: So in issues of this magnitude spanning this kind of time frame in a complicated business like the one that we operate in, it's going to be impossible to get complete agreement --

DR. IRANI: Sure.

UNIDENTIFIED MALE: -- on what happened. There's pretty good documentation here of some issues. I would just like to hear from you why you think we're here. What ultimately led us to this day?

DR. IRANI: I -- you know, I think it snow-balled. You know, I think initially there was something and -- I had to make corrections at some point Dr. Koon (indiscernible). The spotlight is on you and things snowball.

You know, when I first came here, it was a rocky start, and I was new to the area. I think that the evaluation that Dr. Koon laid out where I started the year rather rough, and then at the end of that evaluation it will say "He showed great improvement by the end of it and was a great resident."

I think that pattern went through initially with my intern year. And unfortunately when I got to orthopedics, I wasn't -- it's -- I wasn't given the feedback or direction that I came to expect. It was a different environment. I think Dr. Koon became frustrated because I kept asking questions. I wanted more, and perhaps maybe I do lack insight, but I was never given the opportunity to gain that.

And I think at that point -- and, you know, I mean, to be honest, Dr. Koon declared it was his personal vendetta when I sent that e-mail. He was upset and he kept on referencing that he would fire me on the spot. I think at that point there was a very marked change in the tone, and it became very personal, unfortunately. I think we got off on the wrong foot, and oftentimes in surgery that's all it takes, unfortunately.

I think I've made my mistakes. I'm not perfect. But I think if you look at the remediation -- each of the letters, if you notice, things aren't often repeated. The showing up late, stuff like that, all that stuff -- more work for other residents -- doesn't carry over to follow-up letters, which shows I was striving to do better.

But I think at that point it just sort of snow-balled and they had made up their mind that it wasn't -- like Dr. Koon and Walsh, it was a personal decision that they weren't happy with my care and weren't able to work with me.

UNIDENTIFIED FEMALE: Did you worry about the patients? I mean, like the one who called and said her knee was (indiscernible). Was there any -- I mean, do you worry about your patients?

DR. IRANI: Yeah.

UNIDENTIFIED FEMALE: Do you worry about how they're doing?

DR. IRANI: And, I mean, that -- and that spine patient, like I -- I mean, I texted Grabowski after I was off of the service. I said, "How is she doing?" And that patient, like -- you can talk to her -- she loves me. She -- I think I had great interaction with her. You know, I've come back at 9:00 p.m. at night to post-op check my patients -- sometimes gone home and come back.

Yeah, I definitely worry about my patients. We all do. As physicians, we can't unless we don't. So, absolutely. I think that's part of being a physician. It's part of working hard.

UNIDENTIFIED FEMALE: I mean, I agree you wonder how we get there. So a lot of what's in here (unintelligible) lack of empathy or caring, that's not something I can say "go buy a textbook and read it." That's something that you've got to have innately within you.

DR. IRANI: Uh-huh.

UNIDENTIFIED FEMALE: Do you feel that you have that as a quality? Because it doesn't always appear that you've demonstrated it.

DR. IRANI: I think where that came from were two nursing complaints, is where it came from. In that first complaint, I learned that I need to demonstrate better. I think Dr. Bynoe and Dr. Jones also said this. They said they had no problems with my care, but you need to work on demonstrating it.

And I think that's a little bit of my personality. I think I'm a little bit laid back. But if you -- again, you are welcome to poll the ER nurses, and I'll stand by whatever they say; you're welcome to poll the floor nurses, and I'll stand by what they say.

But I think -- the ancillary staff gets along with me. I think -- you can pick patients I have seen. You know, I'll come back and see patients when they're off service. I really think that I have had positive patient interactions. A lot of them remember me. This spine patient, you can call her up. I haven't talked to her in months. You can call her up right now and ask her what she thinks of me, and I'll stand by whatever she says.

UNIDENTIFIED MALE: Prior to this period in your life, DR. Irani, have you ever had any other issues with professionalism, empathy, accountability? Have those ever come up in your professional life?

DR. IRANI: No, sir.

MS. HILL: Any questions from the committee? Dr. Koon and Dr. Walsh, do you have questions for Dr. Irani?

DR. WALSH: Afraaz, some of what I'm asking you about is in response to what you were just saying a moment ago. You mentioned that with the first patient with the arm injury, you said you did not perform a fracture reduction. Did you

touch the patient's arm?

DR. IRANI: I touched the patient's arm as I did my --

DR. WALSH: What did you do?

DR. IRANI: I did a sensory exam.

DR. WALSH: Did you lift the patient's arm?

DR. IRANI: I don't recall. I did not do a reduction. I don't know if I lifted the arm or not.

DR. WALSH: Okay. One of the statements the nurses made was that you had lifted the arm in a callous fashion, and it was the same way that the former attending (unintelligible) moved the patient's arm in a similar fashion.

You know, moving on the next (unintelligible) trauma female 375. Why do you think there's such an enormous disconnect between your perception of events and the nurses' perception? You've shot holes in what they've had to say, but why do you think that there's this, you know, 180-degree diametrically opposed perception of what happened down there?

DR. IRANI: I'm not disagreeing the patient's care was not substandard. I don't think the patient should've been in the ER for three and a half hours without fractures being reduced.

DR. WALSH: I'm talking about during your management of the patient, not prior, because the three and a half hours was before you got there, right?

DR. IRANI: Right.

DR. WALSH: So I'm talking about the period of your management, which is what they came to us about. Why do you think there's such a huge gap?

DR. IRANI: Could you reference some specific examples of their complaints?

DR. WALSH: Well, their whole description of how you manage the patients -- I don't want to sit them side-by-side.

DR. IRANI: Sure.

DR. WALSH: Basically, you've challenged what they've said about what took place.

DR. IRANI: Right. I mean, you can look in the chart. There is documentation of local and there's documentation of systemic anesthesia, and there's -- I believe there's documentation from Dr. Toussant about the pain. So if there's an allegation of pain management, that's in the chart. That's one thing. What else is there?

DR. WALSH: I guess what I'm getting at is from a more philosphical standpoint. Why is a picture painted there that is totally opposite of what you're describing? You're describing something that's totally opposite. And let me ask a follow-up question. Was the trauma attending Dr. Jones called to the trauma bay?

DR. IRANI: I wasn't there when he was there. I

don't know.

DR. WALSH: Was he called to the trauma bay?

DR. IRANI: I don't know.

DR. WALSH: You and I have talked about that, Afraaz.

DR. IRANI: I don't know. You said he was, but I don't know. I wasn't there. I never saw him down there.

DR. WALSH: All right. Are you aware that he was called to the trauma bay?

DR. IRANI: You told me that. That's all I know.

DR. WALSH: Are you aware of any other instances where the orthopedic traumatologist was called to the trauma bay because of concerns by the nurses about the resident's care?

DR. IRANI: No.

DR. WALSH: I'm not either. We've referenced a number of patient scenarios here, two of Dr. Grabowski's patients, the one who was in the staff clinic that there was a discrepancy between when he asked you to get the MRI and when you were actually going to get it; the second one, the patient with the threatened paralysis. There was the man with the arm injury that I just referenced. There was trauma female 375. There was my patient with the pain medicine. And there was the hemophiliac with a possible compartment syndrome.

Is it your contention that in every single one of

those cases that you rendered appropriate care and that the things that you're being challenged about your management by the variety of people involved here today are -- they're all wrong?

DR. IRANI: I don't think it's a black-and-white, wrong-or-right. I don't think -- the question can be asked that way, I think there's always improvement in patient situations.

DR. WALSH: Well, let's talk about mine in particular that we haven't spent much time with. This patient had a shoulder reconstruction. She phoned you -- or her husband phoned the night of her surgery. And can you just recount what you told her regarding pain medicine?

DR. IRANI: I asked her if there was any weakness, pain, paresthesias, and assessed her if there were any worrisome signs, and I was worried about a surgical complication. And he said -- she said no, so I okayed five more of oxycodone.

DR. WALSH: Five more pills or five more milligrams?

DR. IRANI: Five milligrams more.

DR. WALSH: And I talked to you about what the patient explained to me. Do you recall that?

DR. IRANI: I do -- not completely. I mean, if you want to refresh my memory. I guess.

DR. WALSH: Well, when she -- the nurses told me that she had pain problems the night before. I called her, and she said that yes, she had called the night before, that she was

having pain, and that she said you told her to take five 5-milligram pills of oxycodone every three hours.

And I said, "No. Probably what happened there was that -- that's 25 milligrams. He probably said two 5-milligram pills," giving you the benefit of the doubt. She said, "No. I specifically asked, 25 milligrams, five pills?" and he said yes. So is it your contention that she wasn't telling the truth?

DR. IRANI: No. I think you asked what happened on the phone call, so the phone call happened and I okayed five milligrams. There was a second phone call, right -- there was a second phone call that happened about an hour and a half, two hours later. The patient was now at 20 milligrams Q4, which is Dr. Mazoue's standard naïve narcotic post-op shoulder pain dose. So now she was at the naïve dose.

And she called again, and I again assessed her, just as Dr. Hoover said -- any changes? Said no. And I okayed five more. And he said, "Where do I go from here?" I said, "Just as we were doing, you continue to dose as we were doing -- as we had done. We'll spread it out over four hours."

Now, this was like a three o'clock in the morning conversation. I can understand there was miscommunication. And from this -- after this, when patients call me, I have them repeat it back to me, because I want to make sure this won't happen again.

I don't know if the miscommunication happened on my

part or her part, but that's also why I told Dr. Justin Walker the following morning on rounds -- I said, "Look, you're on the service. This patient called. Here's what happened. If you can just follow-up and make sure everything went according to plan. Here's what I thought I told her." And that's why the call was made the following morning.

DR. WALSH: Another question is, have I interacted with you at all regarding possibilities for your future after orthopedics?

DR. IRANI: Sure. Yes.

DR. WALSH: Can you explain that to the committee?

DR. IRANI: You just said if I don't want to do orthopedics that -- and you want to do industry that here are some options, if you want to do something else.

DR. WALSH: Okay. Who's actually the first attending that brought it up to you?

DR. IRANI: Dr. Guy.

DR. WALSH: Dr. Guy. So in terms of your statements about the fact that your future has been irreparably harmed, et cetera, there's actually been steps by the orthopedic faculty to possibly help you in that area; is that true?

DR. IRANI: I think it would be a smooth exit if I quit and went to something else. Yes.

DR. WALSH: Out of curiosity, who is the third resident you're referring to that is possibly being fired or

investigated? Who is that?

DR. IRANI: What are you talking about? What do you mean?

DR. WALSH: You said the attrition rate in the program, if there was three residents --

DR. IRANI: Right.

DR. WALSH: -- there was one two years ago that was terminated for lying, your situation. Who is the third person?

DR. IRANI: Oh, there was a person who went to family medicine, right?

DR. WALSH: There's a person who withdrew. There was never --

DR. IRANI: Right.

DR. WALSH: -- any academic issues.

DR. IRANI: I understand, but that's still an attrition rate. When we talk about attrition rate, we talk about people leaving a program, whether it be for personal reasons, conflicts, or being forced out. And my point was when we talk about attrition in programs, they always say how many people leave a given program? And our rate is significantly higher than the national average.

DR. WALSH: And after your suspension, prior to your termination, Dr. Hydorn (ph) and Dr. Hoover saw you in the hospital at approximately 11:00 p.m. or 11:30.

DR. IRANI: Uh-huh.

DR. WALSH: Can you explain what you were doing there?

DR. IRANI: I was cleaning out my locker.

DR. WALSH: At 11:00 p.m.?

DR. IRANI: Yeah. I was on the way back -- I forget from where, but -- I think I was riding back from Ohio.

DR. WALSH: And you said the program was under investigation by the ACGME regarding duty hours.

DR. IRANI: Uh-huh.

DR. WALSH: Why would you say that?

DR. IRANI: Just stating the facts.

DR. WALSH: Okay. Can you elaborate on that?

DR. IRANI: ACGME is investigating duty hour violations with our program.

DR. WALSH: How are they aware of possible duty hour violations in our program?

DR. IRANI: You can ask them that. I don't know.

DR. WALSH: Okay. Is it true that you sent them a list of potential duty hour violations --

DR. IRANI: I don't -- I don't --

DR. WALSH: -- used our department's duty hour violations?

DR. IRANI: I don't see the purpose of this. I contacted ACGME to express my issues with the program.

DR. WALSH: So a moment ago you said you didn't know

how they'd be aware of duty hour problems, and now you're not wanting to talk about it?

DR. IRANI: Well, I don't -- they did not disclose to me what exactly they went to, if there was other stuff. I don't know all that's entailed. I don't know.

UNIDENTIFIED FEMALE: (unintelligible).

DR. IRANI: Pardon?

UNIDENTIFIED FEMALE: (unintelligible).

DR. WALSH: He's the one that brought it up, and that's the reason I wanted to ask.

DR. IRANI: I just wanted to state the facts.

DR. WALSH: I'm asking questions for the facts, too.

DR. IRANI: Okay.

DR. WALSH: And last questions. Have you accessed the hospital computer system after your suspension and prior to your termination?

DR. IRANI: Yeah. I had notes that needed to be signed.

DR. WALSH: No other reasons?

DR. IRANI: I don't recall all the reasons I accessed the hospital system.

DR. KOON: I've got a couple questions.

DR. IRANI: Sure.

DR. KOON: One is regarding that hemophiliac patient

that was admitted on the 1st of March.

DR. IRANI: Yeah.

DR. KOON: And that admission occurred one day after you had a very long discussion with Dr. Grabowski and Dr. Voss on Tuesday regarding your treatment and encounter with the spine patient, who loves you; is that correct?

DR. IRANI: It was a morning I was on call, so that evening.

DR. KOON: So you met with Drs. Grabowski and Voss on Tuesday the 28th; is that correct?

DR. IRANI: To be honest, I don't recall the exact date. That sounds about right, but I don't recall the exact day.

DR. KOON: There are e-mail documentations from Dr. Grabowski and Dr. Voss stating that you met with them on Tuesday the 28th. Would you agree to that?

DR. IRANI: It could be. It's probably true. I just don't remember off the top of my head, if you're asking me. I'm sorry, I don't. I don't recall that day, but --

DR. KOON: Are you aware that Dr. Voss wrote a memorandum of record regarding that meeting that you had with Dr. Grabowski and (unintelligible)?

DR. IRANI: Probably. I don't recall specifically. Is it in the packet?

DR. KOON: It's in 81.

DR. IRANI: Okay.

DR. KOON: About halfway down Dr. Voss says, "Ultimately, Dr. Irani did admit shortcomings in terms of his assessment and compulsiveness about thorough patient examination, but I think he failed to have any true insight into the level of concern that we would expect that he would demonstrate in the care of a patient who was at risk for being paralyzed." Do you see that statement?

DR. IRANI: Uh-huh.

DR. KOON: Do you agree with that statement?

DR. IRANI: I think I understood there was a risk for long-term paralysis, and that's why I called my attending. If the question is did I understand the gravity of the situation, I think I would say yes.

DR. KOON: Would you agree that Dr. Voss and Dr. Grabowski did not think you demonstrated that gravity --

DR. IRANI: I don't know -- I don't know what their thoughts were. I mean, that might be their interpretation.

DR. KOON: I'll read it again.

DR. IRANI: Okay.

DR. KOON: "Ultimately, Dr. Irani did admit shortcomings in terms of his assessment and compulsiveness about thorough patient examination, but I think that he failed to have any insight -- any true insight into the level of concern that we would expect that he would demonstrate in the care of a

patient who was at risk for becoming paralyzed." Do you see that sentence?

DR. IRANI: Yeah.

DR. KOON: And it continues, "It seemed Dr. Irani's description of the events were consistent, but there failed to be a recognition or a demonstration of true care for the patient's condition in this situation." Do you see that sentence?

DR. IRANI: Uh-huh.

DR. KOON: Do you agree that that was Dr. Grabowski's and Dr. Voss' concern, and that's why he put that in this statement?

DR. IRANI: I don't know how you want me to interpret Dr. Voss' letter any different than you can, sir. But if that's what -- I believe that was his contention if that's what he's writing.

DR. KOON: How about the next-to-the-last sentence, "My sense and that of Dr. Grabowski was that there is a failure of recognition of the amount of care required for orthopedic spine patients"? Do you see that sentence?

DR. IRANI: I do. Yes, sir.

DR. KOON: Do you now recognize that Dr. Grabowski and Dr. Voss had very grave concerns that you failed to recognize the amount of care required for an orthopedic spine patient?

DR. IRANI: That's their statement.

DR. KOON: Did you subsequently enter a delayed clinical note in the computer about your evaluation of that patient?

DR. IRANI: Uh-huh.

DR. KOON: How long after that did it occur?

DR. IRANI: I think within 72 hours -- or 48 or 72 hours.

DR. KOON: So they met with you on the 28th of February and you went into the computer and put that note in there on the 1st of March; is that correct?

DR. IRANI: I don't recall the exact dates, but if that's what the computer shows, it's probably correct.

DR. KOON: Can you give me a little -- can you tell me why you went into the computer 72 hours later and put a delayed clinical note in the computer?

DR. IRANI: They had requested documentation. Initially, I was told my documentation was inaccurate, so I could not put a note in. But they still wanted documentation, so I decided I should put it in. I don't think it would cause any harm.

DR. KOON: You say that -- you said that your documentation was inaccurate?

DR. IRANI: No, I didn't say that. They wanted more documentation afterwards. I was told that my physical exam was

incorrect; however, after looking back, I know my physical exam was the exact same one Dr. Grabowski had actually written down at a six o'clock note, therefore accordingly I could write down the same thing.

DR. KOON: Actually, your note did not include any measure of neurosensory testing or strength testing; is that correct?

DR. IRANI: Which note?

DR. KOON: Your note of the morning of the -- the morning the patient went to surgery.

DR. IRANI: Do you have it?

DR. KOON: I do not have it in front of me. No.

DR. IRANI: I'd have to see it. I don't know. I thought I did. That's per Dr. Grabowski's note. My --

DR. KOON: So when you called Dr. Grabowski and -- you told him your findings he said, "That's inaccurate. Don't write it in the chart"; is that correct?

DR. IRANI: He said, "That doesn't make any sense."

DR. KOON: Okay. What else did he say?

DR. IRANI: I don't recall the entire conversation. It's been a couple months ago.

DR. KOON: Did he say, "Are you sure?"

DR. IRANI: I don't recall.

DR. KOON: Did he ask you that three times?

DR. IRANI: I'm not sure.

DR. KOON: Well, he said, "Are you sure? Because that's a profound change from her pre-op -- from her postoperative status." Does that ring a bell?

DR. IRANI: I don't recall the exact conversation, but I know I told him my physical exam findings. He was concerned and came by and examined the patient. I don't know what exactly he did or did not say, but I do know I conveyed to him that there was a grave finding, so --

DR. KOON: So you're not sure exactly what he said on the telephone?

DR. IRANI: I know that he told me my physical exam doesn't make sense.

DR. KOON: But there have been other telephone conversations that you remember in detail and that you documented for us today; is that correct?

DR. IRANI: I don't know which -- what you're referring to. Could you please explain?

DR. KOON: I have a couple questions about the hemophiliac patient.

DR. IRANI: Okay.

(Audio cuts out briefly)

DR. KOON: Dr. Voss and Grabowski had a long discussion with you about documentation and thoroughness and so forth, and then the following day at 11 -- the next day at 11:00

p.m. there was a patient who was admitted to the hospital for hemophilia and an enlarging and painful calf.

You had a written note dated 29 February at 11:00 p.m., and you dictated a note at midnight on the 1st of March. Dr. Wood wrote a note at one o'clock in the morning -- 1:06 and directed you to see the patient at four o'clock the next morning. And that e-mail is Page 82. "I finished writing my consult note" -- one, two, three -- four paragraphs up.

"I spoke with Dr. Irani at 1:15 a.m. and informed him that the patient needed to be admitted, and I would like the patient checked in a few hours. I then went to further clarify to give a more specific time frame of 4:00 p.m. I left the ER where the patient was at approximately 1:15. I informed Dr. Irani of my physical findings and told him that if the patient had worsening of symptoms that I wanted to be contacted immediately." Is that your -- is that consistent with your recollection of those events that night?

DR. IRANI: Sounds about right.

DR. KOON: Okay. Subsequently in the chart there's a note from SCOA at 2:29 a.m. and another note at 3:39 a.m. And then the next note in the chart is a chief resident note at 6:05 on the 1st of March. Did you have any notes that were missing in the computer from your dictated note at midnight through the Dr. Wood's note at 6:05?

DR. IRANI: So the question is do I have any missing

notes in the chart?

DR. KOON: Right. Is there -- if that's -- if that's my --

DR. IRANI: No. I think --

DR. KOON: -- findings in the record, are there any notes in there that I'm missing that you wrote?

DR. IRANI: Dr. Koon, I think we already addressed this, that ideally I would've written the note at that time. I examined the patient at midnight. The morning exam was at 6:00 a.m. An interval check, Dr. Wood told me 4:00, but I did it at 2:30, which was close to the halfway mark.

I had to apologize to Dr. Wood because I did not do it at 4:00 a.m. like you had asked me to, and I left it at that. And I think we already talked about that I think we all make mistakes, and I've made my share of mistakes. I did not deny that to you when I met with you. I did not deny that to Dr. Walsh when I met with him. I think that's part of learning.

DR. KOON: So you did not follow your chief resident's instructions that night; is that correct?

DR. IRANI: I did an interval exam.

DR. KOON: Okay. And you subsequently put a delayed clinical note in the computer and that note was put in on the 3rd of March at 12:20 that night; is that correct??

DR. IRANI: I don't know exactly what time it was, but if that's what the computer shows, I'm sure it's accurate,

sir.

DR. KOON: And you documented a physical exam that you performed at 2:30 in the morning on the 1st of March; is that correct?

DR. IRANI: If that's what the record shows, sir.

DR. KOON: Did you oversleep that morning?

DR. IRANI: I was late to rounds. I think that's it. I apologized.

DR. KOON: Was that one of the remediation measures that we had put in place?

DR. IRANI: In December you told me that I was doing fine in terms of my being on time. You said you would let me know if I'm being tardy. That was at our November 21st meeting.

UNIDENTIFIED FEMALE: Dr. Koon, are these questions for clarification based on his testimony?

DR. KOON: Yes, ma'am.

DR. IRANI: I would also add that I'd been late to rounds three times my PGY 2 year. All patients have always been seen.

DR. KOON: You were very specific very early in your presentation that I boasted about firing Dr. Lamoreaux. Do you remember that conversation?

DR. IRANI: I remember you boasting about firing Dr. Lamoreaux.

DR. KOON: And I used that word, "firing Dr. Lamoreaux"?

DR. IRANI: I don't know which exact words you used. I did not quote you in my testimony. I simply said you boasted about firing him. Whether it's firing or termination or trying to get rid of -- that's why I didn't quotes when I addressed you.

DR. KOON: If I did fire him, would that be an accurate statement? If I said -- if I was bragging about firing Dr. Lamoreaux, would that be an accurate statement?

DR. IRANI: I don't get -- I don't see what you're getting at.

DR. KOON: Dr. Lamoreaux, in fact, was not fired. He finished his residency in a delayed fashion.

DR. IRANI: Right. Right. Because he --

DR. KOON: So if I said that he was fired, then that's an inaccurate statement on my part.

DR. IRANI: Could've been. I don't know. Could've been. I know Dr. Lamoreaux had to file a lawsuit in order to get reinstated and you refused to educate him when he came back.

DR. KOON: So you know that I refused to educate him. How would you know about that?

DR. IRANI: Word gets around.

DR. WALSH: I would add this: "incorrect

word -- "gets around" apparently." That's not true.

MS. HILL: I'm not sure this is pertinent to today's decision.

DR. WALSH: Okay.

DR. IRANI: Okay.

(Unintelligible simultaneous speaking)

DR. WALSH: That's fine.

DR. KOON: But Dr. Irani stated that I boasted about firing a former resident, and so I'm trying to clarify the fact that if I boasted about that, it would've been inaccurate on my part because he wasn't fired. So for that -- for that comment to have veracity, there would have to be some type of documentation.

You also admitted that -- earlier in your statement you admitted to duty hour violations; is that correct?

DR. IRANI: I'm sorry. Come again.

DR. KOON: You admitted to duty hour violations?

DR. IRANI: Yeah. And I wrote that in my initial complaint addressed to Kathy Stevens, so, Dr. Koon, I imagine (unintelligible).

DR. KOON: I've got a log of the New Innovations documentation report regarding duty hour violations. Were those reported in the New Innovations?

DR. IRANI: (No verbal response).

DR. KOON: They are? So every duty violation that you've ever had is included in that chart?

DR. IRANI: I would say when all residents are violating duty hours and all residents in New Innovations show they are within duty hours, I think it's a system-wide problem. It's not just me. If it was just me, it would be a problem. But all residents across the board are doing this, and it's a system-based problem. I brought it up to you earlier with that e-mail.

DR. KOON: So when you violated a duty hour, that is not going to show up -- if you violate duty hour regulations, is that going to show up on your documentation or your duty hour on New Innovations?

DR. IRANI: I'd have to review it. I know there are some in there. I'll have to go through --

DR. WALSH: Well, are you telling the truth, what you're putting in New Innovations or not?

DR. IRANI: Let me just say that all the residents are allegedly following according to New Innovations, but the violation rate is the same across all the junior residents. So if you can say -- if we're forced to be doing something, I don't know if you can say we're reporting things inaccurate when we don't really have a choice as residents.

DR. WALSH: So are you saying that not only you are not telling the truth in New Innovations but all the other residents are?

DR. IRANI: I'm not saying we're not telling the

truth. I'm saying that violations are occurring across all residents.

DR. KOON: Isn't it true that you wrote the ACGME in Chicago and documented a 33 to 50 percent rate of duty hour violations in post-call residents?

DR. IRANI: I don't see how that's relevant.

DR. WALSH: Did you do it or not?

DR. IRANI: We have ACGME violations. I think that's ACGME's decision.

DR. KOON: He's stating that he's violated duty hour violations, but they're not recorded. Now, he's saying that all the residents do it. And so he says everybody does it, so I'm trying to establish how many of my residents are doing that that I don't know --

DR. IRANI: So if I give you --

DR. KOON: -- that. He wrote a letter to the ACGME and said 50 percent of my post-call residents are violating duty hours. So I --

DR. WALSH: (unintelligible). He's the one who stated the entire program was under investigation.

DR. KOON: I wasn't going to bring up the ACGME.

DR. IRANI: Well, I think it's important to know that a third party thinks that there's significant violations of this program.

DR. KOON: And why does a third party think there's

significant violations of this program?

DR. IRANI: That's going to be their investigation.

DR. KOON: Is their investigation going to be based on the letter that you wrote to Chicago?

DR. IRANI: I don't know what their investigation is based on. They might have other things. I don't see how this is relevant, ma'am.

DR. KOON: Okay.

MS. HILL: I don't think we're going to agree on an answer to this and (unintelligible).

DR. KOON: All right. You also said that there was false documentation in statements presented at the GMEC. Were you there at the GMEC meeting?

DR. IRANI: No, but I saw a letter presented to the GMEC.

DR. KOON: Okay. So you're -- you having knowledge of false statements presented -- being presented at the GMEC is not correct; is that a fair statement?

DR. IRANI: If the letter that I received was not a representation of what was presented at the GMEC, then I have been misled. But if that was the letter presented, then I stand by what I said earlier.

DR. KOON: You also stated in your presentation that I said that I would have fired you on the spot. Is that true?

Is that a true comment of what you said?

DR. IRANI: Yes. I said it in my statement, yes.

DR. KOON: And you appear to be very knowledgeable of the ACGME requirements for programs. Is that something that I would be able to do as a program director?

DR. IRANI: I don't know all the ACGME guidelines about how to fire to a resident.

DR. KOON: Okay. You also stated that he, meaning me -- "he changed the level of remediation." Is that a correct statement?

DR. IRANI: If it's what I said, yes, sir.

DR. KOON: All right. But in reality, that's not a decision for the program director to do. As stated in our memorandum of record, these are faculty decisions that are forwarded to the GMEC for approval. These aren't individual decisions. Is that a fair statement?

DR. IRANI: I don't know what happened at a faculty meeting, Dr. Koon.

DR. KOON: Okay. You brought up a patient of Dr. Grabowski's in a staff clinic where he wanted to get an MRI and instructed you to do that, and you stated that you spoke with the staff, couldn't get that done, spoke to the chief resident Dr. Wood, and then you got the MRI that day. Is that true? Is that your recollection of those events?

DR. IRANI: Radiology confirmed that we would get

the MRI today if I sent them across the street, and I sent them across the street that day. To be honest, I don't -- you know, if something happened along the way and it didn't happen, I don't know. But to my recollection I got him an appointment, I sent him across the street. My understanding is he did get it done that day. His appointment was made.

DR. KOON: Okay. And when confronted -- when you had that version of your story, what were Dr. Grabowski's and Dr. Wood's response to you during that faculty meeting when you presented your side of the story?

DR. IRANI: I don't know if you have it written down, but I don't recall exactly all the details. I mean, I think I would be just guessing.

DR. KOON: You also stated that in February when you came back on -- came back on Level 2 remediation, you said that you were unsupervised on the service. Could you explain that comment?

DR. IRANI: I just meant there was no senior resident. Oftentimes when I've worked, the programs have a senior and a junior resident on the service. I was the sole resident, and that was my first spine patient I'd ever done as a resident.

DR. KOON: But you did have senior-level and attending coverage for your care of that patient, correct?

DR. IRANI: Well, there's always senior-level

residents and always attendings in the hospital. The only attending -- the only other person on that service was my attending, Dr. Grabowski.

DR. KOON: You also stated in your presentation that you were illegally targeted. Can you explain what you mean by illegally targeted?

DR. IRANI: I think I laid out some discrepancies about my treatment as opposed to my colleague's and some of the behaviors exhibited. And I think, you know, any sort of unfair treatment lends itself to that.

DR. KOON: Okay. You also stated multiple times that you were being punished for doing right or punished for doing wrong. Can you give me an example of when you did something right and you were punished?

DR. IRANI: Well, to my understanding, you said the trauma case managers complained about my behavior. I've talked to them. And if you guys want to talk to them as well and get a neutral third opinion -- they thought I did a great job and they keep asking me to come back. I thought I did -- I thought from feedback that they personally gave me that I did a good job in their rotation, but it was used as another incidence of poor, substandard care.

DR. KOON: You also stated several times in your presentation that due process for the last 18 months has been lacking. Before your letter to the ACGME, was there any e-mail,

letter, any type of communication with anybody relating to your lack of or unfair due process?

DR. IRANI: I don't think I said over the past 18 months. I think one of the examples I gave in my statement was in regard to my filing a grievance within ten business days and that being denied. I think that happened in January -- fairly recently.

DR. KOON: So other than that one episode, is there any other area where you've been lacking due process?

DR. IRANI: I haven't done a thorough examination. I just presented some -- what I thought were the easiest and quickest-to-grab examples today.

DR. KOON: You also mentioned that you brought your concerns to appropriate local committees. Can you tell me which committees you brought that to, when you did it, how many, and if there's any documentation of any of that?

DR. IRANI: Sure. I think the appropriate committees is outlined in the grievance council. There's Step 1.1, 1.2. You go to yourself, Dr. Walsh, Stevens. Then you go to the grievance council. I think I've outlined. I don't think those addressed the issues.

DR. KOON: Okay. You also mentioned that all the other residents are assigned to operate at the VA. Are you aware that starting in July none of the residents are going to the VA?

DR. IRANI: Last I heard it was still up in the air. I don't know the details. That could be the case.

DR. KOON: It is the case.

DR. IRANI: Okay.

DR. KOON: So -- that's it.

MS. HILL: Dr. Walsh?

DR. WALSH: Just one other question. Afraaz, Have you tape-recorded anybody's conversations other than the one you did with Dr. Abel?

DR. IRANI: With Dr. Abel? No.

DR. WALSH: So no other conversations with residents, attendings, or anybody else --

DR. IRANI: No.

DR. WALSH: -- you've tape-recorded?

DR. IRANI: No.

DR. WALSH: You've never left your phone on so somebody else could listen or --

DR. IRANI: No.

DR. WALSH: -- anything like that?

DR. IRANI: No.

MS. HILL: Dr. Koon, you now have up to 5 minutes give a concluding statement.

DR. WALSH: I guess what I would say in conclusion is -- I summarized things before at the end of our statement, and I guess what I would say is that I think that Afraaz's responses

here today speak for themselves regarding defensive, evasive story-telling, avoidance of responsibility, patently false statements that there's paperwork evidence to -- I'm really shocked that you would make, quite frankly -- to the contrary.

And I guess I would end it like we began it. This is not somebody we wanted to fail. This is somebody who I wanted to succeed. We worked hard to make him succeed. You know, we don't go through this kind of process in order to just get rid of somebody, so to speak.

There was a point when Afraaz was on my service when my wife stopped by the office and I was in examining a patient or something like that and he said something to the effect of being nervous about how things were going or something. My wife said, "No, no. You've got to understand. Dr. Walsh likes you. I mean, you know, he enjoys having you on the service." And I did. I mean, he's making mistakes and so forth, but these are the things residents make, and those are things that I was addressing.

The things that this is all about here has to do with bigger issues that surfaced elsewhere and then began to surface in one example we've already talked about was with one of my patients. And so, you know, the notion that there was -- in some way there was a witch-hunt or personal issue or, you know, some reason that we were -- Dave or I or anybody else on the faculty was trying to drum somebody out of the program is just

-- it's bogus and I think that the documentation here speaks for itself, that we were trying to do the right thing, trying to do it in a fashion that was restorative. There's a number of memos in here from Dr. Stevens, another one from me. It specifically states that the whole process is not punitive, that it's something that is -- the goal is remediation and return to the program. And, in fact, when it seemed like things weren't going to work that way -- you know, he alluded to the one resident who withdrew from the program a number of years ago. He withdrew as a PGY 2. He basically came to us and told us that his -- he had gone into orthopedics because his father and his older brother were orthopedic surgeons. He was doing it to please them, and he concluded he didn't really want to do it, and he entered family practice and completed a residency here, so --

DR. KOON: Sports medicine.

DR. WALSH: -- in sports medicine, ironically enough.

The -- so from the standpoint of there being sort of a -- somehow a negative culture within the department that's trying to get rid of residents, there isn't anything that supports that whatsoever. So --

MS. HILL: (indiscernible) concluded? Okay. Dr. Irani, you have up to five minutes to give your concluding statement.

DR. IRANI: I think I already laid out my case in my opening statement. This has been treatment that's been

substantiated by my co-residents. It's been treatment that has been different than compared to my co-residents. It's been derogatory and racially-based insensitive comments directed at me. I think I lay out all my stuff in the opening statement, and -- again, I -- I'm encouraged I'm speaking in front of a neutral third party. Anything here you have questions about, I'm more than happy to substantiate everything I told to you. You're more than welcome to poll the trauma case managers, poll any of the nurses and get their opinions of what they think about me. I'll stand by that. I care about my patients. I care about my patients a lot. I'd come back at night, checked up on them; calling up on them. And, you know, my goal (indiscernible) orthopedic surgeon. That was my goal when I came here.

Dr. Walsh mentioned he was excited. I was excited to come here to operate, to get some hands-on experience. I loved it. When I came back in February, I loved it. You know, I jumped in. I created a handbook and I was excited to be back. I was really happy. And I just feel like the people charged with my education haven't made that possible, so -- thank you for your time. I know you guys have places to be. (indiscernible) probably later than you expected, so thank you.

MS. HILL: Committee members do you have enough information? All right. Just for the record, I just (indiscernible).

DR. IRANI: Sure.

MS. HILL: All right. Thank you for your time this afternoon. This (indiscernible).

(WHEREIN, the files were concluded.)

CERTIFICATE OF NOTARY PUBLIC

STATE OF MISSOURI

I, Sherri L. Jolley, within and for the State of Missouri, do hereby certify that the tape transcription in the witness whose testimony appears in the foregoing transcript in the caption hereof and thereafter transcribed by me; that said transcript is a record of the testimony given by said witness; that I am neither counsel for, related to, nor employed by any parties to the action; and further that I am not a relative or employee of any counsel or attorney employee of any counsel or attorney employed by the parties hereto, nor financially or otherwise interested in the outcome of the action.

Sherri L. Jolley

U